Patient Intake Form

Patient Information:

Patient Name: _____

DOB: _____

Parents'/Legal Guardians' Names: _____

Address City/State/Zip: _____

Contact information:

Relationship/Cell Phone Number: _____

Relationship/Cell Phone Number: _____

Home Phone: _____

Email: _____

Insurance Guarantor Information:

Primary Insurance: _____

Member Name: _____

DOB: _____

Email: _____

Chief Complaints (top 5 concerns):

1. _____
2. _____
3. _____
4. _____
5. _____

Does your child have a diagnosis? If so, please explain here:

_____

_____

Pediatrician/Family Physician Information:

Name: _____ Phone

Number: _____ Address:

_____

Emergency Contact Info (Name & Phone)

Mom: _____

Dad: _____

Insurance Information:

Carrier: _____

Secondary Insurance: _____ Primary

Insurance Member Name: _____

Insurance group and account number: _____

Additional Information

How did you hear about McNeill Children's Institute? _____

Has your child ever seen an occupational therapist before?

(circle one): Yes No

If so, please indicate the duration of therapy:_____

Does your child receive school-based occupational therapy?

(circle one): Yes No

Does your child receive any other services, such as counseling, speech, etc? Please indicate Type, Name, Contact Info, and Duration: _____

_____

Does your child take any medications? If so, please explain:

_____

Does your child have any allergies? If so, please explain here:

_____

What are your child's strengths?

_____

_____

What are your child's limitations?

_____

_____

What are you hoping to accomplish in therapy?

_____

_____

Please use the below space to provide any additional information that you feel is pertinent to your child's occupational therapy program:

_____

_____

_____

_____

_____

_____

_____

McNeill Children's Institute, LLC
Phone: 401-683-8063
Fax: 401-324-5618
Email: frontdesk@mci-ot.com
www.McNeillChildrensInstitute.com

Informed Consent Form

I,_____ , the parent/legal guardian of

_____ (patient), hereby request and consent to McNeill Children's Institute, LLC to perform treatment and care for my child as prescribed by a physician and/or recommended by an occupational therapist.

I understand and am informed that, as in the practice of medicine, occupational therapy may have some risks. I understand that I have the right to ask about these risks and have any questions answered about my child's condition, prior to treatment. I have carefully read and fully understand this Informed Consent Form and have had the opportunity to discuss it with the treating therapist.

I consent and authorize McNeill Children's Institute, LLC to administer treatment under the direction and supervision of a registered occupational therapist.

Signature of Parent/Legal Guardian: _____ Date _____

Signature of Parent/Legal Guardian: _____ Date _____

Release of Information Form

Please complete the following if you would consent to having McNeill Children's Institute, LLC collaborate with other health or educational professionals who work with your child.

I, _____ (parent/guardian), hereby grant McNeill Children's Institute, LLC permission to communicate with the following person or agency for my child _____ (patient) :

Name/Contact Information:

_____ regarding the following information and as part of their current treatment plan:

____Previous & current medical history

____ Previous & current treatment plan

Other (please specify):

_____

_____

Signature of Parent/Legal Guardian: _____ Date: _____

Signature of Parent/Legal Guardian: _____ Date: _____

Notice of Private Practice Health Insurance Portability and Accountability Act (HIPAA)

I have reviewed the Notice of Private Practice under the Health Insurance Portability and Accountability Act (HIPAA) and have accepted the privacy practices, legal duties, and rights concerning my health information. I also understand that the information supplied is required by applicable federal and state law to maintain the privacy of my health information.

Signature of Parent/Legal Guardian: _____ Date: _____

Signature of Parent/Legal Guardian: _____ Date: _____

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COVID Procedures Form

Patient Name: _____ DOB: _____

McNeill Children's Institute is considered a medical facility and is therefore bound to follow CDC procedures regarding COVID. We require the use of masks by our Staff and parents until further notice.

I agree to abide by the COVID rules in place at this facility. (Updated 6/7/21)

Signature of Parent/Legal Guardian: _____ Date: _____

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Consent for Photographs and/or Videotaping

Patient Name: _____ DOB: _____

1. I, _____ , as the client/parent/legal guardian of the above named patient, hereby consent to the use of recording devices that will be used for the sole purpose of: (check all that apply)

    - ☐ Training purposes
    - ☐ Supervision purposes
    - ☐ Other: _____
    - ☐ No photography/videos for any reason

2. I understand that I may withdraw consent for videotaping/picture use at any time.

3. This form has been fully explained to me and I understand its contents.

Signature of Parent/Legal Guardian: _____ Date: _____

Signature of Clinical Supervisor: _____

Date: _____

Permission and Waiver of Liability for Outdoor Activities

Patient Name: _____ DOB: _____

- ☐ I hereby give my consent for the above named patient to participate in outdoor activities during appointment sessions with the McNeill Children's Institute (MCI).
- ☐ I agree to apply any sunscreen, tick and/or bug spray to my child prior to attending a session where my child will be attending outdoor activities, as seasonally appropriate.
- ☐ I hereby release MCI and its administrators, directors, and employees from any and all liability from property damage, personal injuries, or other claims arising from or in connection with this child's participation in approved activities, including claims that are known and unknown, foreseen and unforeseen, future or contingent.
- ☐ I authorize the recognized adult leaders in attendance at any MCI activity to select and secure medical attention as may be necessary for my child as a result of an injury or other events requiring emergency care while I am not in attendance at such an event.
- ☐ I hereby release said MCI from any and all liability on account of such selection or authorization for any and all damages which occur on account thereof.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____

Cell Phone: _____

Date: _____

Preferred Hospital: _____

Family Medical Insurance: _____

Notice of Parent/Legal Guardian Responsibilities

(signature required at end)

Financial Responsibility

- McNeill Children's Institute, LLC may verify the client's benefits as a courtesy. Quoted benefits are not a guarantee of benefits, and the client is ultimately responsible for verifying their insurance benefits.
- If applicable, McNeill Children's Institute, LLC will submit insurance claims to the primary insurance company on the client's behalf. Policyholders are responsible for submitting claims to their insurance company in regards to their Out-of-Network benefits.
- Not all services provided by McNeill Children's Institute, LLC are covered by insurance. Meetings, consultations, additional reports, paperwork and absences (that do not conform to our cancellation policy) are not covered services and will not be billed to private insurers.
- Insurance can take 2-4 weeks to process. Once McNeill Children's Institute, LLC has received an Explanation of Benefits (EOB) from your insurance company, you will be sent an invoice for any remaining balance due.
- Payment is expected within 30 days of the invoice date. After 30 days the client's credit card on file will be billed for any remaining balance.
- Please note that the co-payment is due at the time of service. Deductibles and coinsurance will be requested at the time of service.
- We currently accept cash, check, and all major credit cards. There will be a $35 service fee for all returned checks.
- Services will be suspended if there are unpaid invoices past three months without any communication to us regarding your balance. Additionally, bills that remain unpaid following three invoices will be forwarded to an outside collection agency.
- **The client is ultimately responsible for all charges of rendered services.**

Duration of Services

Individual and group therapy sessions typically run 60 minutes in length. Therapists provide direct treatment with their clients for 50 minutes and will use the last 10 minutes of the session for

consultation and training with parents/caregivers. This wrap-up is an essential piece of our therapeutic intervention for teaching each family concepts, vocabulary, newly learned skills, and how to help generalize these skills. Parents/caregivers play a vital role in the success of their children.

Drop Off/Pick Up Times

- Parents/caregivers must be prompt in picking up their child 10 minutes before the therapy session ends.
- Clients and siblings should remain in the waiting room until greeted by a therapist. Please do not ask our therapists or receptionist to watch your child.
- During the therapy session, parents are welcome to relax in the waiting room, run errands, or grab a cup of coffee.

Late Attendance

A therapy session will not be extended for a client that is late, as we have other clients and groups scheduled throughout the morning, afternoon, and evening.

Waiting Room

We expect siblings to maintain appropriate behavior in the waiting room area and to be supervised at all times. If you do leave McNeill Children's Institute, LLC during your child's session, please make sure we have your cell phone number in case we need to call you. We provide toys in the waiting area and ask that you help keep the area clean and clutter-free by returning items to where they belong.

Allergies/Restrictions

When you complete our online New Client Intake Form, you will be prompted to download and complete a series of forms including an 'Allergy Alert' form (also available for download here). This form will be kept in the child's file. It is crucial for every child to have this form filled out, even if your child has no allergies. If there are food preferences or diet restrictions, please make sure this is noted on this form. If you have changes to make, please do so and give it to the front desk as soon as possible. We have a list of clients and their allergies posted inside the clinic, therefore all therapists can be vigilant of client's allergies.

Confidentiality

- McNeill Children's Institute, LLC will keep all personal, medical, and insurance information confidential. Client information will only be released upon receipt of a signed Release of Information form (which is also in the initial packet). Consent for a release of information

may be withdrawn by the client at any time with a written notice signed by the client's parent/guardian.

- McNeill Children's Institute, LLC will not discuss a child's diagnosis, session, progress, and behavior with the client's tutors, friends, or nannies without the parent's written consent.
- We may communicate with clients' caregivers, parents, or other therapists via email, phone, and mail.

Changes to Information

If there are changes to your insurance, address, phone number or email, please let our staff know immediately so that your child's file can be updated.

Additionally, if there are any medical changes/updates (i.e., seizure disorder medication, new doctor/therapist, surgery, etc.) with your child please inform your child's therapist so they can be aware and make any accommodations if necessary.

ACKNOWLEDGEMENT

I acknowledge that I have read, understand, and agree to follow the Notice of Parent/Legal Guardian Responsibilities listed above.

Signature of Parent/Legal Guardian: _____ Date: _____

Thank you for your support and understanding.

We look forward to working together!