Journeys
Occupational Therapy

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(262) 968-2001 Fax: (262) 347-3371
www.JourneysOT.com

PEDIATRIC INFORMATION FORM

Name_____Age:_____DOB:_____Today's Date_____

Parent/Guardian Name: _____

Address_____City/State_____Zip_____

Phone (H):_____(W)_____(C)_____

Email:_____Occupation_____

Other Parent/Guardian Name: _____

Contact info if different than above:

Address_____City/State_____Zip_____

Phone (H):_____(W)_____(C)_____

Email:_____Occupation_____

Emergency Contact:_____Phone:_____

Who referred you to us?_____May we thank them? Yes No

Has your child received Occupational Therapy before? _____ If so, where, for what issue, and for how long?_____

Primary reason for appointment?_____

Does your child have a medical diagnosis?_____

Name of school child attends (if applicable)_____Grade:_____

Is there any recent crisis or stress going on that is important to your child's development?
_____

Please list your child's strengths:_____
_____

Please list areas of concern (your goals for treatment):_____
_____

Is your child receiving any other intervention/treatment? Yes No

If so, what? _____
Primary Physician or Practitioner's name_____Tel #: _____

Primary Physician or Practitioner's name_____Tel #: _____

Please list any medications (including over-the-counter):

_____

Has your child had corrective surgery for strabismus or eye motor difficulties? Yes No

Any other pertinent medical information, including precautions or allergies the therapist should be aware of, especially contraindications to active movement?_____

_____

_____

CONSENT FOR CARE

You have the right to seek a second opinion or to end the evaluation/treatment at any time. You are entitled to information about the methods and techniques used in the evaluation/treatment. You may also ask the therapist for information about her training and credentials.

I, _____, understand that Occupational Therapy and/or Craniosacral Therapy is not a substitute for standard medical care. I will alert the practitioner to any changes in my child's health status, including medication changes. It is my choice to receive Occupational Therapy and/or Craniosacral Therapy for my child with an understanding of the risks and benefits, and I give my consent for treatment of my minor child. I understand that there is no stated guarantee for effectiveness of treatment.

Signature_____Date_____

PAYMENT POLICY

Full payment is due at the time of service, unless other arrangements have been made in advance. Comprehensive evaluation rate is $350, and includes standardized or nonstandardized testing as appropriate, observations, interviews/phone conversations, and written report. Treatment rate is $100 for 50 minute session. Craniosacral therapy is $90 per 50 minute session, or billed at $25 per 15 minute increment. Late arrivals cannot be guaranteed an extension of scheduled treatment time, and will be responsible for full fee. We are not in network with any insurance companies; although we can submit as an out of network provider on your behalf if receiving medically-based Occupational Therapy services. Itemized invoices can be provided at the end of the month for your health card account. Most insurance companies do not cover Craniosacral Therapy, therefore these Wellness Services are available as private pay only.

Cancellations: Please make any cancellations or schedule changes 24-48 hours in advance when at all possible (exceptions for illness and weather-related events); cancellations within 24 hours will be subject to a $50 cancellation fee at therapists' discretion.

Please initial indicating understanding of payment & cancellation policies:_____