Elite DNA Therapy Services
a comprehensive approach

Pediatric Information Form

Patient Name: _____ Date of Birth: _____ Age: _____ M F
Ethnicity: _____ Preferred Language: _____
Current Diagnosis (if any): _____
Home Address: _____
_____
Primary Phone: _____

School Attended: _____ Teacher: _____ Grade: _____
School Phone: _____

Child's Primary Physician: _____
Address/Phone: _____
_____

Child's Referring Physician: _____
Address/Phone: _____
_____

Guardian Information Section
First Guardian Name: _____
Relationship to Patient: _____ Marital Status: _____
Occupation: _____
Primary Phone: _____ (circle one) Cell Home Work
Secondary Phone: _____ (circle one) Cell Home Work
E-mail Address: _____

Second Guardian Name: _____
Relationship to Patient: _____ Marital Status: _____
Occupation: _____
Primary Phone: _____ (circle one) Cell Home Work
Secondary Phone: _____ (circle one) Cell Home Work
E-mail Address: _____

Emergency Contact: _____
Relationship: _____ Phone: _____

Insurance Information Section
Insurance Type: _____Patient Social Security Number: _____
Member ID Number: _____ Group Number: _____
Policy Holder's Name: _____ Policy Holder's DOB: _____

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Patient Name: _____ DOB: _____

Pediatric Occupational Therapy Intake Form

What are your primary areas of concern? _____
_____
_____
_____
_____

What are your goals for Occupational Therapy? _____
_____
_____
_____

Medical History

Please Check All That Apply:

[ ] Chronic ear infections
[ ] Tubes
[ ] Tonsils/Adenoid Surgery
[ ] Reflux
[ ] Poor weight gain
[ ] Poor sleep
[ ] Asthma
[ ] Lyme disease
[ ] Abnormal muscle tone
[ ] Torticollis
[ ] Frequent antibiotic use
[ ] Frequent fevers
[ ] Colic
[ ] Abnormal Lab results
[ ] Cardiac Issues
[ ] Compromised immune system

[ ] Is good negotiating playground equipment
[ ] Was/is developmentally delayed
[ ] Enjoyed belly time as an infant
[ ] Did not tolerate being placed on belly as an infant
[ ] Avoids climbing, swinging, sliding
[ ] Is good with hands (fine motor skills)
[ ] Met all motor milestones on time
[ ] Is clumsy

Has your child ever had significant illness? [ ] No [ ] Yes, please list: _____
_____
_____

Has your child ever been hospitalized? [ ] No [ ] Yes, please list: _____
_____
_____

Does your child have medical precautions? [ ] No [ ] Yes, please list: _____
_____
_____

Has your child ever had any surgeries? [ ] No [ ] Yes, please list: _____
_____
_____

Does your child have any allergies? [ ] No [ ] Yes, please list: _____
_____
_____

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Patient Name: _____ DOB: _____

Is your child on any medications? [ ] No [ ] Yes, please list: _____
_____
_____

Is your child receiving any other services such as Speech, Physical Therapy, Special Education, Early Intervention, etc.?
[ ] No [ ] Yes, where: _____
_____
_____

Check off all special equipment does your child may use:

[ ] Wheelchair
[ ] Eye glasses
[ ] Hearing Aids
[ ] Braces
[ ] Walker
[ ] Communication Device
[ ] Crutches
[ ] Other: _____

Prenatal & Birth History

Please list any significant prenatal or birth history *(weeks gestation, birth weight, APGARS)*:

_____
_____
_____

[ ] Premature
[ ] Full term
[ ] Low birth weight
[ ] IUGR
[ ] Weeks Gestation _____
[ ] Breech Birth
[ ] C-section Birth (planned)
[ ] Emergency C-section
[ ] Vaginal Birth
[ ] Forceps Delivery
[ ] Vacuum Delivery
[ ] Preeclampsia
[ ] Gestational Diabetes
[ ] Breast fed
[ ] Poor suction/latch
[ ] Bottle fed
[ ] Multiple Ultrasounds
[ ] Oxygen at Birth
[ ] NICU stay
[ ] Duration in NICU____
[ ] Other:_____

Developmental History

Fill in the blanks to describe your child to the best of your ability

Sat at_____ months/years
Stood at_____ months/years
Ran at_____ months/years
Dressed at_____ months/years
Toilet trained at_____ months/years
Crawled at_____ months/years
Walked at_____ months/years
Talked at_____ months/years
Fed self at_____ months/years

Please list any motor development concerns you have (i.e. gross motor, fine motor, oral motor, motor planning, fear of movement, fear of heights, etc.)_____
_____
_____

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Patient Name: _____ DOB: _____

Academic History

Check off all that apply to your child:

[ ] Does well in school
[ ] Is challenged by school
[ ] Is challenged by reading
[ ] Is in a self-contained classroom
[ ] Does well with the exception of: _____
[ ] Receives resource/ tutoring for: _____
[ ] Is an A B C D F Student
[ ] Is challenged by writing
[ ] Is not enrolled in school

Please list any academic concerns you have_____
_____
_____

Please list any specific teacher concerns _____
_____
_____

Evaluation & Therapy Services

Please list any previous occupational therapy evaluations completed and recommendations_____
_____
_____
_____

Please list any previous psychological/neuropsychological/psych-educational evaluations completed and recommendations_____
_____
_____

Behavior/Social History

Check off all that apply to your child

[ ] Is social and engaging
[ ] Has difficulty paying attention
[ ] Poor coping skills
[ ] Unable to self-calm
[ ] Extremely sensitive to criticism
[ ] Has difficulty listening
[ ] Is very busy and active
[ ] Prefers to play alone
[ ] Has tantrums
[ ] Is well behaved
[ ] Pays attention
[ ] Listens well
[ ] Does well with change
[ ] Understands safety
[ ] Takes turns with peers
[ ] Is aggressive
[ ] Does not like new places/ people
[ ] Does not like crowds
[ ] Has difficulty with transitions
[ ] Quickly escalates without apparent cause
[ ] Is easy going
[ ] Follows directions well
[ ] Plays well with other children
[ ] Makes good eye contact with adults and peers

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HIPAA Release Form

Patient Name: _____ DOB: _____

Release of Information

[**X**] I authorize the release of information including diagnosis, records: examination rendered to me and claims information. This information may be released to and from the staff and clinicians of Elite DNA Therapy Services along with the following people/places:

Name of Referring Doctor: _____
Specialty: _____
Phone #: _____ Fax #: _____

Name of Primary Doctor: _____
Specialty: _____
Phone #: _____ Fax #: _____

Name: _____
Specialty / Relationship: _____
Phone #: _____ Fax #: _____

Name: _____
Specialty / Relationship: _____
Phone #: _____ Fax #: _____

Name: _____
Specialty / Relationship: _____
Phone #: _____ Fax #: _____

This release of information will remain in effect until terminated by patient or guardian in writing.

_____ _____
Printed Name of Parent/Guardian Relationship to Patient

_____ _____
Signature of Parent/Guardian Date

_____ _____
Witness Signature Date

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Patient Name: _____ DOB: _____

Consent for Treatment of Minors:

This is to certify that the information on the intake forms are accurate to the best of my knowledge. I give permission to Elite DNA Therapy Services to provide treatment for my child. I verify that all legal guardians are aware of and give consent for this treatment as well.

_____ _____
Printed Name of Parent/Guardian Relationship to Patient

_____ _____
Signature of Parent/Guardian Date

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Patient Name: _____ DOB: _____

Policies of the Elite DNA Therapy Services

Fees for Clinical Services
At Elite DNA we accept many of the major insurance plans, single case agreements, and private pay. Please inquire about our fees, as the rates may be different depending on which provider you are seeing. Please know that you may be billed for telephone calls, written reports or other services that specifically require the provider's time outside of the scheduled appointment.

Missed/Cancelled Appointments
A patient who fails to appear at or cancels less than 24 hours of an appointment will be charged a $100 fee and/or may no longer be seen at this clinic. Please remember to reschedule ahead of time and we will try our best to accommodate you. Since "things happen," patients will be permitted to miss one appointment without being penalized per 6 month. However, please know that repeated "no-shows" may jeopardize your ability to receive treatment.

Lateness
Due to stringent billing requirements, we will be unable to see patients who are more than 15 minutes late for their appointment. Please call to let us know if you are running late and we will be happy to reschedule your appointment, as needed. However, you will incur the same $100 fee or stop of services if you are not able to keep your appointment.

General Medical Consent (for psychiatry)
By signing this form, the patient or the patient's legal representative hereby consents to general and medical care, including but not limited to medical services, X-ray and laboratory examinations rendered to the patient by or under the general or special instructions of the physician practicing within the Elite DNA Therapy Services .

Emergency Services (for psychiatry only)
The on-call services are for patients of Dr. Metheny and are reserved for emergencies only. Please call: 239-223-2751 and press 9.

Confidentiality and Release of Information
All information disclosed within sessions is confidential and may not be revealed to anyone outside of the Elite DNA Therapy Services without your written permission, except for disclosures as required by law. The law does require clinicians to report to the authorities any reasonable suspicions of child or elder abuse, or danger of harm to self and/or to others unless protective measures are taken.

To the extent necessary to determine insurance benefits or liability for payment and to obtain reimbursement, Elite DNA Therapy Services may disclose portions of the patient's medical record and account file to any person or corporation that may be liable for all or any portion of the patient's charges, including but not limited to insurance companies, health care service plans or workers' compensation carriers.

Financial Agreement
It is a patient's responsibility to know his/her insurance coverage for services, as some services and general medical coverage may be provided by two separate plans. Our office staff is happy to help answer questions and help with this process.

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Patient Name: _____ DOB: _____

Patients in poor credit standing with Elite DNA Therapy Services will make their co-payments or payment in full at the time of their visit. We reserve the right to assign unpaid bills to a collection agency.

If you have any questions not covered by this statement, please feel free to ask for clarification.

The undersigned certifies that he or she has read, understands, and accepts the terms and conditions of this form. The undersigned is either the patient or is duly authorized to sign this form and receive a copy.

_____ _____
Printed Name of Parent/Guardian Relationship to Patient

_____ _____
Signature of Parent/Guardian Date