PEDIATRIC OCCUPATIONAL THERAPIST
SAN FRANCISCO, CA

# Consent for Treatment

Child's Name: DOB:

Parents:

Address:

Telephone: (day) (eve)

Email:

Referred By:

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**Emergency Contact**

Name: Relationship to Child:

Telephone:

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**Allergy Alert / Dietary Restrictions**

I, *(please print name)* ,

hereby assert that the above named child has the following allergies and/or food restrictions:

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**CONSENT FOR TREATMENT and RELEASE & EXCHANGE OF INFORMATION**

I authorize and direct Allison Atwood to perform appropriate assessment and treatment procedures upon the above named child. I further authorize and direct Allison Atwood, having assessed and/or treated the above named child to release any appropriate information acquired in the course of the assessment and treatment to the following agencies, facilities, schools, or related professionals:

School:

Medical Doctor:

Psychologist/Educational Therapist:

Speech Therapist/Physical Therapist:

Other:

Insurance & Policy Number (only if you plan to seek reimbursement):

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# Consent for Treatment

**PAYMENT AGREEMENT**

I have read and understand the attached letter stating policies of practice, including the cancellation policy. A cancellation after 8:00 AM the day of treatment will be charged at the full treatment rate. If your treatment time is before 10:00 AM, please call by 5:00 PM the previous business day to avoid being charged.

I agree to pay Allison Atwood the full amount of any and all fees related to services rendered. Payment is expected at the time of service.

I understand that if I am seeking reimbursement from my health insurance company, I must file a claim for benefits independently.

**FEES ARE AS FOLLOWS:**

| | |
|---|---|
| Assessment & report: | $950 |
| Assessment w/school visit & report: | $1200 |
| Treatment: | $170/session (50 minutes) |
| Treatment Plan: | $350 (includes review of records, written goals, and a parent meeting) |
| Consultation (one time appointment): | $225/session (60 minutes) |
| Reports & Home programs: | $170/hour |
| Travel time: | $170/hour (billed in 15 minute increments) |

**Responsible Party Signature:**

**Name (print):** **Relationship to child:**

PEDIATRIC OCCUPATIONAL THERAPIST
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# Credit Card Authorization Form

Please print out and complete this authorization form. ALL INFORMATION WILL REMAIN CONFIDENTIAL.

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Cardholder Name:

Billing Address:

Credit Card Type: ☐ VISA ☐ MasterCard ☐ American Express

Last 4 digits of Credit Card:

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I authorize Allison Atwood, MS/OTR/L to charge my credit card for agreed upon services rendered, in accordance with Allison Atwood/PlayWrite Therapy Policies.

**CARDHOLDER – PRINT NAME, SIGN, AND DATE BELOW**

Name:

Signature:

Date:

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SAN FRANCISCO, CA

# Referral Questionnaire

Child's Name: DOB:

Parent's name(s): Occupation:

Occupation:

Address:

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School Name: Grade:

Teacher:

Referred By:

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What do you hope to gain from your child's occupational therapy assessment and/or treatment?

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Does or has your child received any other evaluations or therapies (OT, SLP, PT, psychologist, etc.)? If so, please include service and with whom.

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What are your child's strengths/interests?

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Describe how your child likes to spend time.

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SAN FRANCISCO, CA

# Referral Questionnaire

Please describe your child's developmental challenges and when you first noticed them.

What are your primary concerns for your child?

**Developmental/Health History**

1. To the best of your ability, please indicate the approximate age your child met each developmental milestone:

| | |
|---|---|
| Sat without support | Crawled** |
| Walked without assistance | How long did he/she crawl? |
| Spoke first word | Spoke in two word phrases |
| Stopped using bottle | Fed self with fingers |
| Potty trained | Fed self with spoon |
| Started dressing self | Dresses self w/o help |
| Buttoned shirt | Tied own shoes |

2. Was your child born after a full term pregnancy? If no, length of time.

3. Were there any complications during pregnancy/birth? If yes, please explain.

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# Referral Questionnaire

4. Has your child had a major illness or hospitalization?

5. Did your child enjoy being held from infancy to two years of age?

6. Was your child difficult to calm as a baby?

7. Has your child ever had seizures? If yes, when?

8. Does your child have problems in any of the following areas? (please check).

☐ Vision ☐ Speech ☐ Hearing ☐ Balance

Other? Please explain

9. Does your child have a history of ear infections? When/how often?

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# Referral Questionnaire

10. Does your child take any medications? (please list).

11. Does your child have any allergies or food restrictions?

12. Has your child received a medical diagnosis? (if yes, please note when & by whom).

**Family History**

1. Siblings (name/ages)

2. Is there any history in your immediate or extended family of learning problems, motor problems, mental illness, or similar difficulties that your child is experiencing?

3. Please note family hand dominance. R=right; L=left; M=mixed

Child Mother Father

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# Referral Questionnaire

4. Has your child experienced the death of a family member, close friend, or pet? (if so, please note when).

5. Has your child witnessed or been the victim of crime or abuse?

6. Are there current stresses in the family or child's life?

7. If your child was adopted, do you have information about the birth mother's health and pregnancy or any information about parent family history?

**Communication/Play Skills**

1. If your child is nonverbal, please describe how your child communicates and the types of vocalizations your child uses.

# Referral Questionnaire

2. If your child is verbal, please describe your child's verbal abilities (vocabulary, ability to stay on topic, etc.)

3. Describe your child's typical play skills. Please include information about ages of the people your child plays with; if your child chooses to be a leader, follower, or a loner; how many people your child is comfortable playing with at once; and whether your child prefers a few close friends or a lot of acquaintances, etc.

**Self Care/Daily Routines**

1. Describe your child's typical mealtime routine. Please include typical foods, any food sensitivities, where your child eats, use of utensils, typical appetite, and behaviour during meal or snack times.

2. Describe how your child gets dressed. Please include the types of clothing your child wears, how independent your child is, how long it takes to get dressed, and typical behavior during dressing and undressing.

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# Referral Questionnaire

3. Describe your child's typical bath time routine. Please include level of independence, your child's like or dislike of bath time, and your child's behavior before, during, or just after bath time.

4. Describe your child's level of independence and behavior during the following activities:

Teeth brushing:

Hair brushing:

Washing hands & face:

5. Describe your child's toileting skills. Please include level of independence, frequency of daytime accidents, bed wetting, awareness of toileting needs, etc.

6. Describe your child's typical bedtime routine, including significant behaviors and any strategies you use during this time.

7. Describe your child's typical wake up routine, including significant behaviors and any strategies you use during this time.

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# Referral Questionnaire

8. Describe your child's typical night sleep, including number of hours, where your child sleeps, bed wetting, number of times your child wakes up, nightmares, etc.

**Behavior, Attention, Self-Regulation**

1. Describe how your child transitions between people, environments, and activities. Please include level of independence during transitions, need for transition object, advance preparation, etc.

2. Does your child seem irritable at predictable times of the day? If yes, please describe the times of day and the events that seem to trigger irritability.

3. Does your child seem happier, more engaged, or more cooperative at predictable times of the day? If yes, please describe the times of fay and the events that trigger these behaviors.

4. Does your child use any strategies to help sustain focused attention? If yes, please describe.

# Referral Questionnaire

5. Describe how your child approached and explores a new environment. Include information about how they interact in a quiet environment compared to an environment with many people or stimuli.

6. Describe how your child approaches a new activity or toy. Include information about how your child initiates new activities; your child's understanding of how to play with new toys; does your child use a toy in a variety of ways or is the play always the same, etc.

**Sensory Components**

1. Describe your child's reaction to touch. Include information about your child's behavior regarding being touched, touching other people or things, clothing likes or dislikes, how your child uses touch to explore, sensitivities, etc.

2. Describe how your child reacts to movement. Include information about types of movement your child likes or dislikes, the frequency that your child seeks movement, any avoidance of playground equipment, your child's behavior regarding being moved or being off the ground, sensitivities, etc.

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# Referral Questionnaire

3. Describe your child's body awareness and safety awareness. Include information about your child's ability to maneuver around peers, adults, and objects; does your child bump into people or knock things over; awareness of danger; etc.

4. Describe your child's reaction to sounds. Include the types of sounds your child enjoys or dislikes, your child's ability to filter out irrelevant sounds, your child's reaction to loud sounds, your child's ability to follow verbal directions, etc.

5. Describe your child's visual attention. Include information about sensitivity to light, ability to attend to relevant visual information, ability to sustain visual attention, what typically catches your child's visual attention.

**School Aged Children**

1. Does your child have a listening or attention problem?

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# Referral Questionnaire

2. Does your child have difficulty with handwriting or fine motor tasks?

3. Does your child reverse letters or numbers when reading or writing?

4. What are your child's academic strengths?

5. What are your child's academic challenges?

6. Describe your child's ability to complete homework. Include level of independence, need for breaks, external supports (snacks, 1:1 attention, music, etc.), the amount of time needed, etc.

7. Describe your child's ability to keep track of personal belongings and organize personal belongings (i.e. homework, bedroom, desk, etc).

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# Policies

We are glad to assist you and your family with occupational therapy services for your child. Please read this information carefully so that you become familiar with our policies and methods of practice. Please initial at the end of each section.

**Services Offered**
We offer occupational therapy services including evaluation and treatment in the areas of sensory integration, fine motor, visual motor, handwriting, gross motor, self-care, and oral motor/feeding skills.

We provide clinic-based therapy and home and school consultation. Following a complete evaluation/screening, a treatment plan will be recommended (duration and frequency) as appropriate. Treatment goals will be developed at that time. If there is no history of ongoing therapy or assessment within the past year, an evaluation is necessary prior to the initiation of therapy.

Initials

We will accept an occupational therapy evaluation completed at another center. Prior to starting treatment, we will need to review the evaluation and any other relevant records. It is possible that we will need to do additional testing during your child's initial treatment sessions. Following 4-6 treatment sessions, we will write up goals and a treatment plan with your input, and schedule a one hour meeting with you to review our observations and collaborate on suggested goals. The fee for this service is $350.

Initials

**Cancellations**
Our goal is to find a time that is mutually convenient to see your child. Please give as much notice as possible if a therapy appointment needs to be cancelled (i.e. holidays, medical appointments, etc.). If a cancellation is necessary due to illness, please call by 8:00 AM the morning of your appointment. An appointment not cancelled by 8:00 AM will be charged at the regular treatment rate. If your treatment time is before 10:00 AM, please call by 5:00 PM the previous business day to avoid being charged.

We are unable to hold treatment times for extended cancellations, such as summer break. If you need to cancel more than 4 sessions in a 2 month period, we will need to offer your treatment spot to another child on our waiting list. When you return, we will do our best to find a therapy time for your child.

Initials

PEDIATRIC OCCUPATIONAL THERAPIST
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# Policies

**Parent/Professional Conferences**
Brief conversations with parents/caregivers following therapy sessions are considered an essential part of the therapy program. Scheduled conferences outside of treatment sessions with parents and/or professionals will be billed at the regular treatment rate. Progress reports can be written for your child upon request. Please allow 2-4 weeks for any testing to be completed and a report to be written. Reports are billed at the regular treatment rate.

Email should be used for scheduling purposes only. If you would like to discuss your child's progress, have specific treatment questions, or any concerns that you would like to discuss outside of therapy sessions, please schedule a meeting with your therapist. Meetings can be done over the phone or in person. We welcome your questions and look forward to working together to provide a comprehensive therapy program, while maintaining your child's privacy.

Initials

**Payment**
Payment is required upon arrival to each therapy session and at the first assessment session. We accept credit cards or checks as payment. If you pay by credit card, we will only need to swipe your card once and after that you will be billed automatically after each treatment session. You will be sent an invoice marked paid after each therapy session. Your credit card number will be kept securely in our credit card payment system.

Initials

**Insurance**
If you are seeking reimbursement from your health insurance company, you must claim benefits independently. We will provide insurance codes for reimbursement; however, we do not accept payment from insurance companies and cannot guarantee reimbursement. You are responsible for full payment for each therapy session.

Initials

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**Responsible Party Signature:**

**Name (print):** **Relationship to child:**

PEDIATRIC OCCUPATIONAL THERAPIST
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# COVID-19 Policies + Procedures

We at Allison Atwood Pediatric Occupational Therapy, are concerned about the health and safety of you and your child. Due to the recent pandemic, we will be reopening with new policies and procedures to mitigate risks of contracting COVID-19 for all staff and families. These policies and procedures are in line with the most updated Centers for Disease Control (CDC) and Federal, State, County and the City of San Francisco guidelines. We will continue to monitor these guidelines in the coming weeks and modify our procedures when necessary based on the agencies' updated reports.

**Social Distancing**

1. Our waiting room and our upstairs office are currently closed. We ask that if your child is able to participate in therapy without a parent/caregiver present, we will greet you at the door and walk them into the clinic. Therapy sessions will continue to be 50 minutes to allow for us to discuss what was completed at the end of the session. This can take place outside at a distance. Caregivers wearing a face covering will be allowed to participate in the therapy session if approved by the therapist.

2. We will make every effort to maintain a distance of 6 feet or more from your child during the therapy session. However, sometimes it is not possible to maintain this distance between the therapist and your child due to the nature of some physical activities. If you are not comfortable with this sporadic close contact, telehealth therapy is recommended as an alternative.

3. There will only be one therapist and one child working in a room at a time to reduce the physical contact and amount of people in the space. We will be working at a modified schedule with at least 15 minutes between each therapy session to ensure that there is plenty of time to sanitize all equipment and all common touch points throughout the clinic such as doorknobs, toilets, and benches.

**Protective Equipment**

1. Face Mask: We will be wearing a face mask at all times during a therapy session. All children 12 years or younger are not required to wear a face covering. If your child tolerates wearing a mask, please have them do so for the therapy session. If they are not able to tolerate wearing a mask, it is acceptable for them to still attend therapy without one.

2. Eye Protection: We will be wearing clear eye protection as an added precaution to limit the spread of infection between children. It is not necessary for your child to wear eye protection.

**Monitoring Clients for Indicative Symptoms**

1. All therapists will be taking their temperature before the start of each day. We ask that you take your temperature (if present for therapy) and your child's temperature before entering the clinic without the use of any fever-reducing medicines such as acetaminophen or ibuprofen. Taken from the CDC guidelines, we request that if you or your child has a fever of 100.4 degrees Fahrenheit or higher to please stay home and let the therapist know by phone, email, or text immediately. The child will not be able to return for in-person therapy sessions until the fever returns to normal or they are cleared by a medical professional. A telehealth therapy session may be an alternative if your child is feeling better and able to participate.

**Health Screening**

1. All families will be sent by email a brief Health Screening Questionnaire at the beginning of the day before your child's therapy session. Please fill out the questionnaire before the therapy session starts. We will not be able to start the session until the questionnaire is complete.

2. If there are any questions on the questionnaire that indicate possible exposure to COVID-19, the therapy session will be cancelled. All therapy sessions will be cancelled and conducted via telehealth until there is a cleared health screening.

3. Please contact your therapist immediately if you or your child, or anyone you have been in contact with, has been diagnosed with COVID-19. If a therapist were to be diagnosed with COVID-19, we will notify all families who may have been in contact with them immediately. This information will remain confidential in accordance with HIPAA and ADA guidelines.

4. If a therapist or family receives a diagnosis of COVID-19, they will not be allowed back to the clinic for in-person therapy sessions until cleared in writing by a health professional and completed the full 14 day quarantine as recommended by the CDC..

PEDIATRIC OCCUPATIONAL THERAPIST
SAN FRANCISCO, CA

# COVID-19 Policies + Procedures

**Sanitation**

1. All therapists and families will be asked to wash their hands upon entering and leaving the clinic for 20 seconds with soap and water. Hand sanitizer with an alcohol content of 60% or higher will be available throughout the clinic to be used during the therapy session when necessary.

2. All parents and/or children will be asked to wash their hands during the session if there is a possibility that they have been contaminated by touching their face, nose or mouth.

3. All areas such as doorknobs, light switches, knobs on faucets, etc/ that were touched by persons in the clinic will be disinfected between therapy sessions using a disinfectant spray or wipe that is approved for use against COVID-19.

4. All equipment and materials used during a therapy session or that may have come into contact with the therapist or child will be disinfected using a disinfectant spray or wipes recommended by the CDC. Therapy sessions will be scheduled with a 15-20 minute window between each session to allow for the disinfectant spray to be effective.

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By signing this document, I understand that my child's therapist, Allison Atwood, is taking measures to mitigate the risks of infection. I will not hold my therapist or Allison Atwood responsible if I, or my child, contact COVID-19 or any other virus.

**Pandemic Agreement**

**Responsible Party Signature:**

**Name (print):** **Date:**

**Relationship to child:**

PEDIATRIC OCCUPATIONAL THERAPIST
SAN FRANCISCO, CA

# HIPAA Privacy Practices

This notice describes how protected health information about your child may be used and disclosed and how you can get access to information. Please review it carefully. "Protected Health Information" (PHI) is information about your child that can reasonably be used to identify your child and that relates to their past, present, or future physical or mental health or condition, the provision of health care, or the payment for care. Federal and state laws require us to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your child's protected health information. We must follow the terms of this notice while it is in effect. Some of the uses and disclosures described in this notice may be limited in certain cases by applicable state laws that are more stringent than federal standards. We reserve the right to change our privacy policies and practices and the terms of this Notice at any time, as permitted by federal and state law. If significant changes are made, the new Notice will be available upon request and posted on site.

**How We Collect and use Information About Your Child:** Allison, other therapists, and/or volunteers (we) collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of referral and consent forms that is either required by law, or necessary to process referrals or other requests for services through our organization.

**What We Do Not Do With Your Information:** Information about your child's medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to referral forms or outside agency reports, or directly or indirectly given to us, is held in strictest confidence. We do not disseminate any information about clients who apply for or actually receive our services that is considered confidential patient information, as restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form. We do not use cookies on our website to collect data from our site visitors. We do not collect information about site visitors. We do use some affiliate programs that may or may not capture traffic data through our site. To avoid potential data capture, simply do not click on any of our outside affiliate links.

**USES & DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION**

The following categories describe the different ways we use and disclose medical information. For each category of uses or disclosures there will be some examples.

- **Treatment:** With your permission, we may use and disclose your child's protected health information to other healthcare providers involved in your child's care.
- **Payment:** We may use and disclose your child's protected health information, with your consent, in order to assist you in obtaining payment for the services we provide. This may include, but is not limited to evaluation and progress reports, treatment notes, or other documentation required by your payment source.

- **Healthcare Operations:** We may use and disclose your child's protected health information in order to perform various operational activities. This may include training programs, accreditation, certification, or credentialing activities.
- **Health Oversight Activities:** We may use or disclose health information to a health oversight agency for activities authorized law. These oversight activities include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Business Associates:** We may use or disclose your child's protected health information to other businesses that assist or support our business, such as facility maintenance, computer technology assistance, accounting, or healthcare staff. We require our business associates to appropriately safeguard your child's protected health information.
- **Required by law:** We may use or disclose your child's protected health information when we are required to do so by law.
- **Public Health Activities:** We may use or disclose your child's protected health information to public health agencies to prevent a serious threat to your child's safety or health or to the safety and health of others (for example reporting a communicable disease).
- **Abuse/Neglect:** We may use and disclose your child's protected health information to appropriate government agencies if we have reason to believe that your child is a possible victim of abuse, neglect, domestic violence, or other crimes.
- **Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose health information about your child in response to a court or administrative order. We may also disclose health information about your child in response to a subpoena, discovery requests, or other lawful process to someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.
- **Law Enforcement:** We may disclose your child's protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.
- **Appointment reminders:** We may use or disclose your child's health information to provide you with an appointment reminder.
- **Your Authorization:** In addition to our use and disclosures listed above, we may use your child's protected health information for other purposes with your written authorization. You may revoke this authorization at any time with a written request. Revoking your authorization will not affect any use or disclosures permitted by your authorization while it was in effect. We cannot use or disclose your child's health information for any reason except those described in this Notice without your written authorization.

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# HIPAA Privacy Practices

**Patient/Client Rights**

You have certain rights regarding protected health information we obtain about your child.

- **Access to Your Child's Protected Health information:** You have the right to access your child's health information. You can request to view it and/or have us make photocopies of the information you desire. All requests for access to your child's health information must be in writing.
- **Amend Your Child's Protected Health Information:** You have a right to request that we amend your child's health information. All requests to amend your child's health information must be in writing including an explanation of why you want the record amended. We may deny your request if the record was not created by us, is not part of the protected health information we keep, or it is determined by us to be accurate and complete.
- **Restrict your Child's Protected Health Information:** You have a right to request additional restrictions regarding our use or disclosure of your child's health information. All requests for additional restrictions to health information must be in writing. Your request must include:
    - What information you want to limit
    - Whether you want to limit how we use or disclose your information
    - To whom you want the restrictions to apply

      We may deny your request under certain circumstances. The law allows us to disclose information without your authorization in response to the following:
        - A court order, subpoena, or warrant
        - Health oversight agencies
        - Report about victims abuse, neglect, or domestic violence
        - Public health activities

- **Accounting of Disclosures:** You have the right to request an accounting of disclosures we have made of your protected health information. This list will not include disclosures made for national security purposes or to law enforcement personnel.
- **Alternative Communication:** You have the right to request that we communicate or send health information to you at an alternate address or by alternate means. All requests for alternative communication regarding your child's health information must be in writing and specify which location or method you want your child's protected health information communicated.
- **Paper Copy of this Notice:** You have a right to request a paper copy of this notice at any time. You may obtain a copy of this notice on our website at: *atwoodtherapy.com*

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# HIPAA Privacy Practices

**Limited Right to Use Non-Identifying Personal Information from Biographies, Letters, Notes, and Other Sources:** Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of PlayWrite Therapy. We reserve the right to use non- identifying information about our clients (those who receive services from or through us) for purposes that are directly related to our mission. No identifying information (photos, addresses, phone numbers, contact information, or names) will be used without client's express advance permission.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

**FOR MORE INFORMATION OR TO FILE A COMPLAINT**

If you want more information about our privacy practices or have any questions or concerns, please contact us. We support your right to the privacy of your child's protected health information.

If you are concerned that your child's privacy has been violated, you may file a complaint with our Privacy Officer or with the US Department of Health and Human Services. We can provide you with the address upon request. We will not retaliate or penalize you in any way if you file a complaint.

PlayWrite Therapy Privacy Officer:
Rebecca Hendricks, MA, OTR/L
PlayWrite Therapy
585 8th Avenue
San Francisco, CA 94118
Telephone: (415) 713-1003

PEDIATRIC
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SAN FRANCISCO, CA

# HIPAA Privacy Practices

**Acknowledgement of Receipt of Notice of Privacy Policy**

☐ I acknowledge that I have received a copy of Allison Atwood's Notice of Privacy Practices.

Child's Name:

Signature of Parent/Guardian:

Name (print): Date:

Relationship to child:

**For Office Use Only: Client was offered the Allison Atwood Notice of Privacy Practices, but written acknowledgement of receipt was not signed because:**

☐ Client refused to sign

☐ Other: