La Vie Est Belle Therapy Services, Inc
Phone Number: 772 999 1977
Fax Number: 772 237 1962
Email: lavieestbelleot@gmail.com

Child's Name: _____

Date of Birth: _____

NEW PATIENT INTAKE FORM

PERSONAL INFORMATION

Child's Legal Name: _____ Date of Birth: _____

Age: _____ Male: ☐ Female: ☐

Mother or Legal Guardian: _____ **Father or Legal Guardian**: _____

DOB: _____ DOB: _____

Please check if it is okay to leave a message	Yes	No		Yes	No
Home Ph: _____	☐	☐	Home Ph: _____	☐	☐
Cell Ph: _____	☐	☐	Cell Ph: _____	☐	☐
Work Ph: _____	☐	☐	Work Ph: _____	☐	☐

Best number to reach you at: _____

Physical Address: _____ Physical Address: _____

Mailing Address: _____ Mailing Address: _____

Occupation: _____ Occupation: _____

Employer: _____ Employer: _____

Who referred you to our office? _____

Who does the child reside with? _____

Who has custody of the child? _____

If primary person bringing child to therapy is not listed above, please list name and contact phone number of that person: _____

EMERGENCY CONTACT: _____
NAME: _____ **PHONE:** _____
RELATIONSHIP: _____

INSURANCE INFORMATION (please fill out ALL areas)

Primary Insurance: _____ Secondary Insurance: _____

Policy Number: _____ Policy Number: _____

Group Number: _____ Group Number: _____

Claims Address: _____ Claims Address: _____

Phone Number: _____ Phone Number: _____

Insured's Name: _____ Insured's Name: _____

Insured's DOB: _____ Insured's DOB: _____

I DO NOT YOU HAVE ANY OTHER INSURANCE COVERAGE FROM ANY OTHER SOURCE OTHER THAT THE ABOVE MENTIONED. Initial ____

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Emergency Medical Release
In the event medical attention is required for your child while the care of LVEBTS, INC., we need your authorization to implement treatment. Please read and sign statement below.

As legal guardian of _____, I give my permission for LVEBTS, INC. to contact emergency personnel in the event of a medical emergency.

Parent/Legal Guardian Signature: _____ Date: _____

MEDICATION/ALLERGY/CONDITION FORM

Medication: Please include prescription drugs, over the counter medications, vitamins, and homeopathic medications.

_____

_____

Allergies/Reactions:

_____

_____

Diagnosis: Please indicate any medical diagnosis or medical condition, with dates if known.

_____

_____

PHOTO PERMISSION **Initial/Date**

1. I give permission for photographing/videotaping of my child for the purposes of treatment, education, and documentation. _____/_____
2. I give permission for photographing/videotaping of my child to be used for advertising, brochure, and/or webspace. _____/_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA):
I acknowledged that I have viewed, read, and understand the HIPAA Policy and have been informed of my rights as a patient's parent/guardian.

Parent/Legal Guardian Signature: _____ Date: _____

AUTHORIZATION AND CONSENT FOR TREATMENT, PAYMENT, AND OPERATIONS:
Please initial the following statements:
_____ I have a prescription from my child's physician to authorize initial evaluation.
_____ I have checked with my insurance company prior to this therapy visit and assert that I have obtained the necessary information regarding limits of coverage, co-pays, and co-insurance.
_____ I hereby give La Vie Est Belle Therapy Services, Inc. permission to evaluate and treat my child, and I understand there will be written, oral, and electronic communication between care providers/physicians, insurance companies, and La Vie Est BelleTherapy Services, Inc. staff. I understand that state representatives for the purpose of insurance certification or licensing and quality assurance may review my child's records. I understand that all practices of confidentiality will be followed in use of the information gathered.

_____ I give La Vie Est BelleTherapy Services, Inc. permission to submit bills directly to the insurance carrier.
_____ I have read and agree to follow La Vie Est Belle Therapy Services, Inc's office and financial policies.

_____ _____
Signature of Parent/Guardian **Date**

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Child's Name: _____

Date of Birth: _____

Child's primary care physician: _____

List the names of the programs and people that have worked or are working with your child outside of La Vie Est Belle Therapy Services, Inc.

Service	Program Name	Teacher/Therapist	Phone #	Dates
Pediatrician/Physician				
Child Care Program				
Preschool				
School				
Occupational Therapist				
Speech Therapist				
Physical Therapist				
Counselor/Psychologist				
Infant Learning Program				
Head Start Program				
Caseworker/Care Coordinator				
Dietitian/Nutritionist				
Specialty Doctor				
Other				

I hereby authorize any prior or present treating physician, therapist, school, hospital, or other health institution, to release all of medical information by any means of communication to La Vie Est Belle Therapy Services Inc.

_____ _____

Signature of Parent or Guardian **Date**

If your child has an IEP through his/her school, please bring us a copy for our records.

If your child has a neuropsych evaluation or any additional testing, please bring us a copy for our records.

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Child's Name: _____

Date of Birth: _____

HISTORY FORM

Please answer the questions to the best of your ability and in as much detail as possible. Please add any information that you feel is important but is not covered on this form.

General History

Child's Name: _____ Nickname? _____ DOB: _____

Current concerns: _____

_____

Has your child previously received occupational, physical, or speech therapy? To address what concerns? Please include where, when, and for how long:

_____

_____

Is your child currently receiving any of these therapy services? Please list providers, locations, and days/times:

_____

Pregnancy & Delivery

Did the child's mother have any illnesses or complications during pregnancy or delivery? Please describe:

_____

_____

Was your child premature? YES NO

Born at how many weeks gestation: _____ Birth Weight: _____

Did your child require any medical procedures before, during, or after birth? Please describe:

_____

_____

Developmental History

Please indicate at what age each major milestone was reached:

Sitting up by self: _____ Crawling: _____ Walking: _____

First word: _____ What was their first word? _____

When did you first become concerned about your child's development?

_____

_____

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Feeding

Did your child have any feeding problems as an infant? Please describe: _____

_____

Was your child bottle fed or breast fed and for how long? _____

Did your child have any colic or reflux issues? _____

Describe your child's current eating habits and typical intake:

_____

_____

Medical History

Please describe illnesses, hospitalizations, or surgeries that your child has had and when they occurred:

_____

_____

Does your child have any allergies? Please list: _____

Does your child take any medications? Please list: _____

Does your child have any medical diagnoses? Please list diagnosis and date of diagnosis:

_____

Has your child had a neuropsychological evaluation? YES NO

If yes, date of most recent evaluation: _____ Name of neuropsychologist: _____

Social History & Living Situation

Please describe your child's living situation (and any recent changes): _____

_____

Siblings' names and ages: _____

If your child was adopted, please answer the following questions: ☐ ☐

Age of adoption: _____ Is your child aware of adoption? YES NO

Previous home experiences prior to adoption: _____

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Date of Birth: _____

Educational History

Grade: _____ Name of school: _____ Teacher: _____

What kind of classroom (e.g., regular ed, special ed, life skills, pull-outs, etc.): _____

Does your child have an IEP? YES ☐ NO ☐

What services does your child receive at school through the IEP? _____

Names of any school therapists? _____

Hearing & Vision

Has your child had his/her hearing tested? What were the results? _____

Has your child had any ear infections? Please list number if known: _____

Did your child ever have tubes placed in his/her ears? When? _____

Has your child had his/her vision tested? What were the results? _____

Does your child wear glasses or hearing aids? For what condition? _____

Personal Information

Please describe your child's personality:

How do you handle discipline issues at home?

Does your child have tantrums? YES ☐ NO ☐

- How often? _____
- How does your child handle changes and variation in routine?
- Please describe your child's sleeping habits/patterns:
- Briefly describe a typical day for your family, especially this child (feel free to use the back of this paper, if needed):

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PATIENT AGREEMENT

La Vie Est Belle Therapy Services, Inc. offers Physical Therapy, Occupational Therapy, and Speech-Language Pathology services for patients referred to our practice. We are a licensed provider who develops individualized treatment plans to identify the services that will best suit your child's therapy needs. We will also work with your primary care practitioner to coordinate your care.

Following the initial assessment visit(s), we develop a specific plan of care (POC) for review and approval by your child's referring provider. Once your child's referring provider signs the (POC), we can begin working with your family to improve your child's condition. We are pleased to serve your Physical Therapy, Occupational Therapy, and/or Speech-Language Pathology needs and encourage your feedback to alert us to anything we can do to provide your child the highest quality of care.

We require certain information from each patient in order to begin providing care. The attached forms need to be completed in order for us to begin serving your child as our patient. Please do your best to complete all the information. If certain information does not apply to your child, please indicate that by noting "N/A" ("Not Applicable") so that we know that you did not overlook anything.

Each healthcare insurance payor has different guidelines for allowing coverage of Physical Therapy, Occupational Therapy, and/or Speech-Language Pathology services. It is helpful if you let us know your healthcare payor when starting service so that we may find out if prior authorizations are needed. If your child is a Medicaid beneficiary, please ask your primary care provider to send us a referral for your initial assessment to fulfill Medicaid requirements. If your healthcare insurance payor does not cover Physical Therapy, Occupational Therapy, and/or Speech-Language Pathology services, you are welcome to make self pay arrangements for the usual and customary pricing of our services.

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INFORMED CONSENT FOR OCCUPATIONAL THERAPY SERVICES

This document (the Agreement) contains important information about the professional services and business policies of clinical staff members at La Vie Est Belle Therapy Services, Inc (LVEBTS). Please read it carefully and note any questions you might have so that they can be addressed during your session. You are asked to sign once you fully understand these policies. Once you sign a copy for your child's file, it will constitute a binding agreement between you and your LVEBTS clinical staff member. You may revoke this Agreement in writing at any time. That revocation will be binding on LVEBTS unless we have taken action in reliance on it; if there are obligations imposed on LVEBTS by your health insurer in order to process or substantiate claims made under your policy; of if you have not satisfied any financial obligations you have incurred.

Occupational Therapy: The "occupation" of children is to thrive, and occupational therapy practitioners work with children and young adults, from infancy through college, and their families to facilitate participation and independence in activities of daily living. Recommended interventions are based on a thorough understanding of typical development, the environments in which children engage (e.g., home, school, playground) and the impact of disability, illness, and impairment on the individual child's development, play, learning, and overall occupational performance. Occupational therapy practitioners collaborate with parents/caregivers and other professionals to identify and meet the needs of children experiencing delays or challenges in development; identifying and modifying or compensating for barriers that interfere with, restrict, or inhibit functional performance; teaching and modeling skills and strategies to children, their families, and other adults in their environments to extend therapeutic intervention to all aspects of daily life tasks; and adapting activities, materials, and environmental conditions so children can participate under different conditions and in various settings (e.g., home, school, sports, community programs).

Clinical staff at La Vie Est Belle Therapy Services, Inc. provide occupational therapy assessment and treatment as described above.

Safety/Physical Contact: LVEBTS Clinicians will assure to the best of their ability that their child patients are kept safe in the office. If a child should engage in behaviors dangerous to her/himself or the LVEBTS Clinician during a session and cannot stop these behaviors independently, the LVEBTS Clinician may restrain (hold) the child in a safe and non-punitive manner until the child is able to refrain from dangerous behaviors. In addition, in the course of assessment or treatment, young children sometimes seek physical contact with the therapist in the form of hugs. Your LVEBTS Clinician will assure that any physical contact is positive and safe. Parents are encouraged to contact LVEBTS Clinicians whenever they have questions about their child's treatment.

Confidentiality: The only way your LVEBTS Clinician will share information about your child or your family with others is if you first sign a "Release of Information" form that specifies who is to receive the information and what is to be shared. You have the right to confidentiality regarding your involvement at LVEBTS. Legal exceptions to confidentiality exist in order to protect you and others, including the following: threat of grave bodily harm to oneself or another person; child abuse or neglect; requested information from your insurance company; and information a collection agency may require if a patient's account is delinquent. Please see LVEBTS's Privacy Practices form for more detailed information.

Benefits and Risks: Occupational Therapy Services can have benefits and risks. Informed consent means being aware of both possibilities.

Benefits include gaining increased independence, increased motor functioning, increased sensory regulation, and overall greater sense of well-being and health.

Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict a person's response to a certain therapy or procedure. There is a risk that OT assessment or treatment may cause pain or injury or may aggravate previously existing conditions.

A patient (or parent/guardian) has the right to ask questions about what type of treatment will be received and discuss with the therapist the potential risks and benefits of each specific recommendation. A patient (or parent/guardian) has the right to decline any portion of treatment at any time during the treatment sessions.

I acknowledge that I understand the benefits and risks of occupational therapy services as outlined above and I wish to proceed with my child's assessment and/or treatment.

_____ (Initials)

Professional Fees, Payment Policies, & Insurance Reimbursement:

Fees: Occupational Therapy Services are billed at $200 for your first evaluation appointment, and $120 per hour for treatment, afterwards; however, LVEBTS Clinicians may negotiate a reduced fee based upon need. Payment is due at the time of each session.

There is no charge for routine phone calls lasting less than 10 minutes. If phone calls take the place of an in-person appointment, if they last for more than 10 minutes, or if significant amounts of time are needed to coordinate a patient's care with other professionals or institutions, these calls will be charged per 15 minute intervals at the hourly rate of the service to which the call relates.

I understand that my initial evaluation session(s) will be billed at or below $200 per hour and all subsequent treatment sessions will be billed at or below $120 per hour.

_____(Initials)

If a patient/family become involved in legal proceedings that require the participation of the LVEBTS Clinician, the patient/family will be expected to pay for their professional time even if they are called to testify by another party. Because of the difficulty of legal involvement, the fees for preparation and attendance at any legal proceeding are higher than the typical fees and will be discussed with the patient/family if this service becomes necessary.

Payment Policies: Fees are collected at each visit for the hours of service performed that day. Fees for activities conducted between visits (e.g., record review, phone calls of more than 10 minutes, school observations, etc.) will be collected at the next visit or by invoice if there are no further visits scheduled. The patient/family will be provided with a statement itemizing the hours for which you/the family are being billed on a monthly (or more frequent) basis. The patient/family will be expected to pay the outstanding balance at that time. LVEBTS Clinicians are unable to have patients run a bill for their services. LVEBTS Clinicians also cannot accept barter for services.

Payment may be made by cash or check at the time of service(s). Please make checks out to La Vie Est Belle Therapy Services.

I understand that I must pay at the time of each visit. I understand that all services provided between visits will be billed and paid at the subsequent visit.

_____(Initials)

Payment delinquencies: There will a returned check fee of $25.00 should there be any problems clearing a check. If for any reason a patient/family does not pay their bill at the time of service, a $50.00 late fee will be assessed for each 30 days that they do not pay. If a patient/family does not pay their bill for more than 60 days and suitable arrangements for payment have not been agreed to, your LVEBTS Clinician has the option of using legal means to secure payment, including the use of collections agencies or small claims court. If such legal action is necessary, the costs of such proceedings will be included in the claim. In most cases the only information released about a patient in such a process would be his/her name, the nature of the services provided, and the amount due.

Insurance Reimbursement: If you have a health insurance policy, it may provide some coverage for occupational therapy assessment and treatment. You will be responsible for requesting a referral from your child's pediatrician/physician in order to initiate treatment. La Vie Est Belle Therapy Services, Inc. will provide you with whatever assistance we can in helping you receive the benefits to which you are entitled. However, you, not your insurance company, are responsible for payment of services at the time of service(s). It is very important that you find out exactly what services your insurance policy covers.

You should carefully read the section in your insurance coverage that describes occupational therapy services. If you have questions about the coverage, call your plan administrator. Of course, we will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, we will be willing to call the company on your behalf.

I have read and understand that I am responsible for any fees that my insurance company does not cover.

_____(Initials)

Cancellation Policy: Since your appointment time is reserved exclusively for you, if you cancel or do not come, your LVEBTS Clinician is often unable to use that time for another patient who needs to be seen. Therefore, once an appointment for any service is scheduled, a patient/parent will be expected to pay for it unless they provide 24 hours advance notice of cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. Illness and emergencies are exceptions to this.

I understand that I must cancel the appointment 24 hours in advance or I may be billed in full for the scheduled appointment.

_____(Initials)

Early Termination (Ending) of Treatment:

A decision on the part of your LVEBTS Clinician for early or premature termination of the professional relationship would be for one of the following reasons: non-cooperation with the services being provided; lack of maintaining frequency of sessions that would support timely completion of the evaluation, treatment or consultation; needed services that your

LVEBTS Clinician is not able to provide; financial non-cooperation; or any other needs of the APG Clinician. Should the professional relationship end prematurely; parents/guardians will be provided with appropriate referrals and recommendations about how to proceed.

Contact Policies & Procedures:

To reach your LVEBTS Clinician by phone, please call her google-voice phone number which is: 772 999 1977. As LVEBTS Clinicians are often not immediately available by telephone, they will check messages during the day, Monday through Friday. LVEBTS Clinicians typically do not check messages over the weekend. LVEBTS Clinicians will make every attempt to return phone calls as quickly as possible. When your LVEBTS Clinician is unavailable, their telephone is answered by confidential voicemail. If your LVEBTS Clinician will be unavailable for an extended time (e.g., vacation or illness), they will provide patients/families with the name of a colleague to contact, if necessary and upon request.

If a patient wishes to communicate with their LVEBTS Clinician by e-mail, it is necessary to sign the Electronic Communications Authorization Form.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during your professional relationship with your LVEBTS Clinician.

I have received and understood the above information. I have been given a copy of this form for my records, and I consent to the agreed upon services for my child. I agree to meet all financial obligations.

Patient's Name: _____

Signature of Parent/Guardian: _____

Signature of Clinician as Witness: _____

La Vie Est Belle Therapy Services, Inc

9015 Americana Rd, Suite 6 Vero Beach FL 32966

Phone number: 772 999 1977 Fax Number: 772 237 1962

Email: lavieestbelleot@gmail.com

Authorization for Consent to Release Medical Records

Institution Releasing Information:_____

Institution Receiving Information: La Vie Est Belle Therapy Services INC

Address: 1450 Old Dixie HWY Vero Beach, FL 32960

Check one: Pick up ☑ Fax ☑ E-Mail ☑

Patient's Full Name:_____

Address: _____

Phone number: 7_____ Date of Birth: _____

Social Security number:_____

Covering Records for the Period from _____to_____

Or check for All Records ☑

I do hereby release the above institution (releasing information) for all legal liability that may arise from the release of the information requested. I understand that this consent is subject to revocation by me at any time, except to the extent that action has been taken based on this authorization I understand that this authorization shall expire without my express revocation after termination of services at our center.

_____ _____

Date Consent signed Signature of Patient / Guardian