Carol Tietz, OTR/L, PA
OT Kid Works
Mill Pond Professional Center ~ 7657 Cita Lane ~ New Port Richey, Florida ~ 34653
(727) 376-1111 ~ (727) 845-1811 Fax
11099 Hearth Rd. ~ Spring Hill, Florida ~ 34608
(352) 683-7117 ~ (727) 845-1811

Biographical Information: Date ___________

Child's Name ________________________________ Date of Birth ___________________ Age _____

Social Security # _____________________________

Address ____

Home Phone ___________________________

Mother's Name ________________________ Cell Phone_______________________

Address ____

Father's Name ________________________ Cell Phone_______________________

Address (if different)____

How did you hear about our services? ____

General Information:

Has your child been diagnosed with a condition? _______Yes _______No

If yes, please explain____

What are your primary concerns?____

Has your child previously received occupational therapy services?

If yes, when and location? ____

Does your child receive other therapy services? Yes _______ No _______

Service received and location ____

What is your child's academic level? Pre-K _______ Grade_______

School/Program name ____

Regular Education _______ Special Education ________ Other _____________________________________

Emergency Information:

Current Medications____

Known allergies______________________________ Precautions _____________________________________

Dietary Precautions/Food Allergies ____

Nearest relative or friend not living in your home ____

Home Phone__________________________ Cell Phone __________________________

Address ____

Physician Information:

Primary Care Physician___________________________________Phone Number_____________________

Referring Physician ______________________________________Phone Number_____________________

Insurance Information:

Primary Health Plan_______________________________ Is this an HMO? Yes_______ No_______

Effective Date _______________ Policy Number __________________ Group Number_______________

Name of Insured ____ Insured's Date of Birth _____________

Insured's Relationship to child __________________ Deductible ___________ Co-pay ___________

Secondary Plan Name ______________________________ Is this an HMO? Yes _______ No_______

Effective Date _______________ Policy Number __________________ Group Number_______________

Name of Insured___________________________________ Relationship to Child ____________________

Consent for Treatment/Authorization of Payment:
I give permission for Carol Tietz, OTR/L, PA and representatives of said organization to treat my child. I understand that I am responsible for all charges incurred, whether or not paid by the above stated insurance. I hereby authorize this office to release any and all information necessary to secure reimbursement from any insurance company to which I have subscribed. I hereby authorize direct payment of claims for my child's occupational therapy services to be made to Carol Tietz, OTR/LPA for authorized medical benefits received within the terms of my insurance. I understand I am responsible for full payment in the event my child's funding source changes and I do not immediately notify Carol Tietz regarding these changes.
Payments can be made in cash or checks made payable to Carol Tietz, OTR/LPA.

Release of Medical Records:
I authorize the release of all medical records necessary to ensure proper care, authorization and payment of medical benefits for my child.

Release for Emergency Care:
I give my consent to any emergency facility and physician to administer necessary treatment to my child. In the event of an emergency, if I cannot be reached. I give my consent for ambulance transport if the situation warrants.

Child's name ________________________________ Name of Physician ___________________________

Physician Phone # ____________________________ Hospital Choice ________________________________

Acknowledgement of Notice of Privacy Practices:

I have been provided with the "Notice of Privacy Practices" provided by Carol Tietz, OTR/L, PA. This notice describes how my Protected Health Information is used and disclosed for the purposes of treatment, billing, and other related operations pertaining to my child's on-going care.

Child's Name _________________________________ Date ______________

Parent/Guardian Signature ____

Child's name ____

Birth History:

Pregnancy Complications: ____

____

Birth Complications: ____

____

Circle: Vaginal/Cesarean Planned/Emergency Birth Weight:_________ Birth Length: _________

Gestational Age:__________________

Developmental History:

At what age did your child:

Roll Over _____________ Walk Unsupported _____________ Finger Feed _____________

Sit Unsupported _____________ Crawl _____________ Cup Drink _____________

Cruise Furniture _____________ Toilet Train _____________ Speak First Word _____________

Medical History:

Has your child had any of the following:

	Yes	No	Details
Heart Conditions			
Respiratory Conditions			
Neurological Conditions			
Ear Infections			
GERD (reflux)			
Hearing Disorder			
Vision Disorder			
Swallow/Feeding Disorder			
Seizure Disorder			
Head Injury			
Sensory Integration Dysfunction			
Other			

Please list all surgeries, including dates and reasons:_______________________________________

____

____

Please list all hospitalizations, including dates and reasons:__________________________________

____

____

Child's Name ___________________________________

Parental Observations:

Do you have any concern in these areas?

	Yes	No	Details
Attention			
Balance/Gross Motor Skills			
Fine Motor Skills			
Coordination			
Muscle Weakness/ Endurance			
Handwriting			
Speaking			
Pain			
Sensory Organization/ Defensiveness			
Behavior			
Social/Play Skills			
Academic Performance			
Hearing			
Vision			
Other			

What are your child's likes?____

What are your child's dislikes?____

What would you like for your child to achieve in therapy?_____________________________

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