849 Menlo Ave. Menlo Park, CA 94025
Phone: 650-323-0805
Fax: 650-323-5262
www.play-steps.com
Theresa Baumert, OTR/L, Director

Thank you for your interest in pediatric occupational therapy. This letter will introduce you to the policies and procedures of this pediatric therapy practice. Welcome!

Evaluations:

Occupational therapy evaluations are individually planned to meet the needs of the child. As parents, you will be the initial source of information regarding your child's development and the nature of the concerns, which led to the occupational therapy referral.

Evaluations generally include two to three hours of testing and/or observation directly with your child. Sometimes additional testing time is needed, or an additional observation at the school site is planned. The testing is then scored. The test scores and observations are interpreted within the context of the initial concerns and the information gathered about the child's functioning in other developmental areas. After the necessary information has been gathered, an evaluation report is written, and a conference scheduled to discuss the findings and recommendations with you.

Therapy:

The occupational therapy program is planned individually for each child. Sessions are generally scheduled for a 50-minute hour, although shorter or longer sessions may be indicated for some children. Progress in therapy is assessed informally on an ongoing basis, taking note of changes in the child's skills or responses to therapy activities. More formal reassessment to measure progress is completed as appropriate, generally at six to twelve month intervals, or when requested by parents. Conferences with parents to review the child's progress are generally scheduled at six to twelve month intervals as well. You are welcome to request a conference at any time.

Regular attendance is usually essential for successful therapy and is strongly encouraged. Of course, we recognize the importance of vacations, and some other cancellations are unavoidable as well, but please be aware that your child's progress in therapy may be adversely affected by irregular attendance. Other than during the summer months, if your child's attendance record drops to 75% or less for reasons other than illness (i.e. averaging one missed session per month for 3 months), your child's therapist will contact you to discuss our concern as to the limited value of continuing therapy on an infrequent basis.

Communication:

Occupational therapy services for children are most effective when they are provided with the whole child in mind. We value frequent communication with parents. We also find communication with other medical, educational and counseling professionals who work with your child to be essential, both in completing a comprehensive evaluation and in providing

successful ongoing therapy. Please keep us informed of events and changes in your child's life, and let us know if there are times when you think communication with your child's teacher or other therapist would be particularly useful.

Termination of Therapy:

When to end the therapy program is usually a decision made jointly by therapist and parents. When it appears that therapy is no longer needed, or when progress seems to have reached a plateau, we will work with you to form a termination plan that is comfortable for your child. Recommendations to discontinue therapy may be based on retesting, or more informal assessment methods. A discharge summary will be written, if requested, which summarizes the child's therapy program and current development.

Sometimes parents need to discontinue therapy before it is clinically indicated. When this is necessary for any reason, we request a minimum of three weeks notice, to allow time for appropriate termination with your child, and for any retesting that may be necessary to summarize the child's program and progress.

Next Steps:

Please send in the following materials before your first appointment:

- Completed registration and developmental history forms (enclosed).
- School records, if relevant. If your child is in special education, please include the current IEP and most recent triennial review.
- Reports from other educational or counseling services provided for your child.
- Medical records, if there have been significant medical issues.
- Completed release form (enclosed). This form gives us permission to communicate with the other teachers/therapists etc. who work with your child; please fill this out with their names and addresses. In addition, please arrange to have all relevant records forwarded, as described above.

If you have any questions about these policies and procedures, or about the payment policies, which follow, please do not hesitate to ask. We look forward to working with your family.

(continued on next page)

Policies and Procedures Regarding Fees

Payment for Services

We ask families to pay all fees at the time of service. For evaluations, we ask that you pay half the fee at the initial appointment, and the balance at the second appointment. When additional services are agreed upon during the course of the evaluation, fees are also paid at the time of service.

For therapy, payment is made at each session. Fees for other services provided as part of ongoing therapy, such as consultation with other professionals, parent conferences, or report writing, are also paid at the time the service is provided, or at the next therapy appointment. During the first week of each calendar month, we will give you an invoice for the services provided the previous month. You will have already paid for the services outlined on the invoice, but this will provide the documentation you need for submitting a claim to your insurance company or flexible spending plan if you wish.

What a Session Includes

PlaySteps' sessions are 50 minutes in length. The services provided in this time include pre-session greeting and check-in, direct clinic time and a brief post-session consultation time with the parent. If you wish to have more time to talk with your therapist, please ask to schedule a meeting time or phone consultation, or to end the session earlier to allow more time to talk.

Therapy sessions are scheduled weekly or twice weekly with a dedicated therapist who will be prepared to treat your child during the scheduled time. This time is determined based on the availability provided by the family and will remain a standing appointment. Change requests will be accommodated based on the therapist's availability (or that of a new therapist, if necessary).

If you are late for an appointment, please make an effort to let your therapist know your projected arrival time. We will not exceed the scheduled time to make up the late start but will make the most of the remaining time.

Fees

A. **Evaluation** $900
This fee includes two to three hours of testing, scoring/interpretation time, a parent conference, and an assessment report. Additional services that may be needed as part of an evaluation, such as a school observation, consultation with other professionals who work with your child, attendance at an IEP meeting, or additional testing time with your child, are billed at $160 per hour. This fee also applies if you must cancel an evaluation appointment with less than 24 hours' notice.

B. **Initial therapy appointment** $220
This fee is for the first therapy appointment only. It includes a typical session fee of $160, plus additional fee of $60 associated with starting a child in therapy. It covers the 50-minute session as well as the additional time required for gathering information and planning the therapy program. However, this fee is waived if your child has an evaluation within this practice as those additional costs are built into the evaluation fee. If your child has had a recent evaluation here, the first therapy appointment is instead charged at the regular $160 rate noted below.

C. **Ongoing Therapy** $165 per 50-minute hour
This fee includes 50 minutes of direct therapy, as well as daily planning and documentation. When a shorter session is indicated the fee is prorated.

D. **Other Direct Services** $165 per 50-minute hour
Other direct services which may be needed as part of ongoing therapy, such as parent conferences, conferences with other professionals involved in the child's care, or school observations, are billed at the therapy rate.

E. **Consultation as part of ongoing therapy** $165 per hour
"Behind the scenes" time, such as telephone consultation with other professionals or time spent writing letters or reports, is billed at this rate.

F. **Travel** $41.25 per 15 minutes
This fee covers a therapist's time spent traveling to and from sessions conducted at a client's home, travel for school observations, etc.

PlaySteps for Developing Kids LLC
...let's play for a change

CANCELLATION POLICY

revised January 2020

If you need to cancel an appointment, please **immediately call your therapist** directly and leave a voice message on her/his clinic extension at (650) 323-0805.

Late Cancellations

A 24-hour cancellation policy is maintained. Unless an appointment is cancelled at least 24 hours in advance, it will be charged as scheduled. If a makeup session is scheduled, there will be a charge for both the cancelled session and the makeup session.

We do make one exception to the 24-hour rule: if the child who has the therapy appointment is ill, there will be no charge as long as you notify us as soon as you know that the child is ill.

INITIALS _____

ILLNESS: Providing a healthy environment for our therapists and children is a top priority.
Please cancel if your child has had, within 24 hours of the therapy appointment, a fever, vomiting, diarrhea, conjunctivitis, exposure to lice or any other contagious condition. We do not want to expose others. If your child has some congestion (without discharge) and only slightly reduced energy, the therapist can generally work on less physically demanding tasks for that session.

We recognize that there are other times when late cancellations are unavoidable, but considering we do save this time exclusively for your child, we appreciate your understanding that we must bill for it.

Sessions Cancelled in Advance

We are committed to providing consistent therapy sessions in order to maximize your child's progress to reach his/her therapy goals. To that end, we reserve a regular therapy time each week exclusively for your child.

While this consistency is a priority, we also want to make the policy workable for families by providing a number of sessions that may be cancelled in advance (i.e. more than 24 hours) without a charge, as well as the possibility of makeup sessions. The policy also takes into consideration the needs of the therapists so that they may use their time productively. The following policy reflects these priorities:

Families may miss 2 scheduled appointments without charge, *provided 24 hours' notice is given,* during each of the following two "seasons" (therapists' absences excluded):

- 2 cancellations January 1 - May 31
- 2 cancellations September 1 - December 31
- The summer months from June 1 to August 31 are exempt allowing for greater flexibility for summer trips, etc.

INITIALS _____

(Please note: If your child is regularly scheduled for two sessions per week, 2 additional missed sessions will be permitted per season without charge.)

Cancellations *not due to illness* that exceed the number allotted for the season will be billed at the regular therapy rate. If the regular therapist's schedule allows, a makeup session can be scheduled within that season *at a time other than the regularly-scheduled therapy time* (based on the therapist's availability).

- If the makeup session is scheduled as a result of the first or second missed appointment, the missed appointment will not count toward the total of missed sessions for that season.
- If the missed appointment exceeds the two "no-charge" appointments for that season, and is therefore charged to your account, there will be no additional charge for a makeup session. Again, the opportunity to schedule a makeup session depends on the therapist's availability.

If your family finds it necessary to take a longer break from therapy sessions within one of the two seasons (and is not able to make up these sessions either beforehand or after), we cannot promise to hold your session time, and we will make that available to other families as needed. If another child fills that time, we will do our best to find a new time that fits your scheduling needs upon your return to therapy. **INITIALS _____**

Exempted Holidays

Cancellations on these holidays are not considered "missed appointments." However, it is up to the discretion of your therapist to offer appointments on these dates. She/he will confirm the schedule in advance and it is optional for your child to schedule an appointment on these dates. If an appointment is scheduled, the cancellation policy applies.

- New Year's Day
- President's Day
- Memorial Day
- Labor Day
- Halloween
- Thanksgiving Day
- The Friday after Thanksgiving
- Christmas Day or Hanukkah
- The week between Christmas and New Year's Day

*If you have a religious holiday that may interfere with your scheduled appointment, please notify us in advance so we can schedule a makeup time.

I have read PlaySteps' cancellation policy and agree to remit for scheduled appointments as described in the policy above.

Parent's signature _____ Date _____

Overview

Cancellations in advance and late cancellations:

MISSED SESSIONS	**1-2 missed session per season**	**3+ missed sessions per season** **(5+ if seen twice a week)**
Cancellations in advance for any reason other than illness (24 hours or more)	No charge Eligible for a makeup session	100% of session fee Eligible for a makeup session at no additional charge, as the session was already paid for.
Late cancellations (less than 24 hours)	100% of session fee. Since the session is already paid for it is not counted as a missed session for the season	100% of session fee. Since the session is already paid for it is not counted as a "missed session" for the season.

Cancellations for illness:

Child scheduled for therapy is ill; family called in under 24 hours	No charge Not counted as a "missed session"

For office use only:
Dx: _____

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Registration Form

Child's Name_____ Birthdate _____

Parent One_____ Home Phone _____ Cell___

Address_____ City_____ Zip ___

Email address _____ Employer _____

Parent Two_____ Home Phone _____ Cell_____

Address_____ City_____ Zip_____

Email address _____ Employer _____

School_____ Grade _____

Teacher_____ Phone _____

Siblings: Name	Birthdate	School	Grade

Referred by _____ Phone _____

Reason for Referral _____

I give PlaySteps for Developing Kids permission to provide OT services for my son/daughter,

_____ child's name

_____ _____ one parent's signature; date

_____ _____ other parent's signature, if required; date

I give PlaySteps for Developing Kids permission to videotape my son/daughter for in clinic use only.

Yes ____ No ____ Initials _____

Are the parents divorced? Please note that if the parents have joint legal custody, the signatures of both parents are required before any services are provided.

Yes ____ No ____ Initials _____

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Pediatric OT Developmental History Questionnaire

Child's Name _____ Birthdate _____

Prenatal and Birth History:

Any complications during pregnancy or birth? Any medical interventions? Please describe.

_____

_____

_____

Medical History:

Has your child had any significant illnesses or injuries? Please describe. _____

_____

_____

_____

	Yes	No
Has your child had frequent ear infections?	_____	_____
Does your child respond consistently to sound?	_____	_____
Has your child's vision been tested?	_____	_____
If yes, please note results _____		
Does your child have allergies?	_____	_____
If yes, please note what he/she is allergic to _____		
Has your child had any seizures or periods of unconsciousness?	_____	_____
If yes, please add details _____		
Any current medications?	_____	_____
If yes, please note medication and purpose _____		

Pediatrician and phone number: _____

Motor Development

Age sat unsupported _____ Age fed self _____ Age pedaled trike _____
Age crawled _____ Age dressed self _____ Age rode bike _____
Age walked _____ Age toilet trained _____ Age tied shoes _____
Does your child seem clumsy or poorly coordinated? _____

_____

Poor suck in infancy? _____ Drooling after 2 ½ years? _____ Difficulty chewing? _____
Any current problems with self-care? _____
Does your child independently manage buttons? _____ snaps? _____ zippers? _____
Does your child hold eating utensils appropriately for his/her age? _____
Cut food independently with a table knife? _____ Hold a pencil appropriately? _____
Handedness: Hand used for writing? _____ Drawing? _____ Brushing teeth? _____
Eating with a fork? _____ Cutting with scissors? _____ Throwing a ball? _____
Age at which hand preference was consistent? _____
Additional comments about motor development? _____

_____

Language Development

Age spoke first word _____ Age put 2-3 words together _____ Articulation ok? _____
Additional comments about speech/language development? _____

Behavioral Characteristics

Does your child get along well with other children? _____
Does your child get along well with adults? _____

Is your child ...?	Yes	No	Comments
Shy?	____	____	_____
More active than others?	____	____	_____
Impulsive	____	____	_____
Wiggly when seated	____	____	_____
Easily distracted	____	____	_____
Socially engaged	____	____	_____
Interested in learning	____	____	_____
Does your child ...?			
Have difficulty sleeping	____	____	_____
Have a limited food repertoire	____	____	_____
Avoid certain food textures	____	____	_____
Suck his/her thumb	____	____	_____
Chew on non-food objects	____	____	_____
Avoid some clothing textures	____	____	_____
Avoid getting hands messy	____	____	_____
Touch objects/people frequently	____	____	_____
Easily become dizzy or carsick	____	____	_____
Enjoy fast-moving rides	____	____	_____
Object to certain sounds	____	____	_____
Object to bright lights	____	____	_____

Please add any other behavioral characteristics or observations _____

What are your child's favorite activities? _____

What things does your child tend to fear or avoid? _____

Educational History

Has your child attended preschool? If so, please note which school, dates of attendance, and any concerns raised by the school.

Has your child attended kindergarten? If so please note which school, dates of attendance, and any concerns raised by the school.

Please note elementary school(s) attended, and any concerns raised by the school(s).

Does your child like school?

Does your child have an IEP? Any special services provided at school?

Has the school recommended any private services for your child?

Has your child participated in any evaluations outside of school, with private therapists or agencies? If yes, please summarize the results, and note dates services were provided and by whom.

Has your child participated in tutoring or therapy services outside of school, with private tutors/therapists or private agencies? If so, please note services provided, when, and by whom.

General

Is English the only language spoken at home? If not, what other language(s) are used?

Do any family members have a history of learning differences, speech/language difficulties, coordination difficulties, or emotional difficulties? If so, please describe.

Please add any other comments that may be relevant for planning your child's evaluation or therapy.

Parent Signature _____ Date _____

NOTICE OF PRIVACY POLICIES AND CONFIDENTIALITY PRACTICES

Please review this notice carefully.

OUR LEGAL RESPONSIBILITY

This notice is to inform you of compliance to the Health Insurance Portability and Accountability Act (HIPAA). We are required by federal and state law to maintain the privacy of your child's health information. We are also required to give you this NOTICE about our privacy policies and practices, our legal duties, and your rights concerning your child's health information. We will follow the privacy practices described in this NOTICE while it is in effect. This NOTICE will remain in effect until we replace it. We reserve the right to change our organization's privacy policies and practices and the terms of this NOTICE at any time, as permitted by federal and state law, and to make the new provisions effective for all protected health information that we maintain. If significant changes are made, the new NOTICE will be available upon request and will be posted at our site. You may request a paper copy of our NOTICE at any time, even if you agreed to receive a copy electronically.

Confidential records and client information are stored in secure areas. Staff with access to protected health information are trained and monitored for compliance in confidentiality and security policies. HIPAA privacy requirements apply to protected health information in written, electronic or oral form. In order to maintain the privacy of all client information, only employees or independent contractors are permitted in our office space. Family members are permitted in shared treatment rooms only when accompanying their child.

CLIENT RIGHTS

- **Access**: You have the right to access your child's health information (i.e. "Designated Record Set). This includes all information pertinent to your child's treatment/intervention decisions, and billing records. You can request to view it and/or have us make photocopies (for a cost) of the information you desire. If the records are in electronic form you can also request those records be sent electronically. All requests for access to your child's health information must be in writing and an appointment time will be set. In certain specific circumstances we may deny your request, but we will tell you in writing of our decision and any reason(s) for the denial. Please contact our privacy officer for the required form. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- **Amendment**: You have the 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. Please contact our privacy officer for assistance. We may deny your request if the information:
    a. was not created by us (e.g. report from another professional),
    b. is not part of the protected health information we keep, or
    c. is determined by us to be accurate and complete.

  If we deny the requested amendment, we will tell you in writing how to submit a statement of disagreement or complaint that can become a part of your child's record.
- **Restriction**: You have the right to request additional restrictions regarding our use or disclosure of your child's health information. All requests for additional restrictions to your health information must be in writing. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. You can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law

requires us to share that information. Please contact our privacy officer for assistance. We may deny your request under certain circumstances. The law allows us to disclose information without your authorization in response to:

a. a court order, subpoena, warrant or similar process,
b. health oversight agencies,
c. report about victims of abuse, neglect or domestic violence, or
d. public health activities.

- **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 (e.g. only by phone or in person). All requests for alternative communication regarding your child's health information must be in writing and specify the location or method you want your child's health information communicated through by our personnel. Please contact our privacy officer for assistance.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about your child for treatment, payment and healthcare operations.

For example:

- **Treatment:** With your permission, we may use or disclose your child's health information to other healthcare providers involved in your child's care (i.e. pediatrician, speech therapist, psychologist).
- **Payment:** We may use or disclose your child's health information to assist you to obtain payment for the services we provide you. This may include but is not limited to: evaluation reports, treatment notes or other documentation required by your payment source.
- **Healthcare Operations:** We may use or disclose your child's health information as it relates to our healthcare operations. This may include agency operations such as performance or quality improvement activities, training programs (including staff and students), accreditation, certification, licensing or credentialing activities, reviewing the competence or qualifications of our healthcare professionals, and evaluating staff performance.
- **Business Associates:** We may use or disclose your child's health information to other businesses that assist or support our business such as computer technology assistance, accounting, and/or healthcare staff. To protect your child's healthcare information, we require our business associates (or those who may come in contact with a child's health information, such as facility maintenance) to appropriately safeguard your information.
- **Required by Law**: We may use or disclose your child's health information when we are required to do so by law. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if they want to see that we're complying with federal privacy law.
- **Abuse/Neglect/Public Health**: We may use or disclose your child's health information to appropriate authorities if we have reason to believe that your child is a possible victim of abuse, neglect, domestic violence or other crimes. We may use or disclose your child's health information to prevent a serious threat to your child's safety or health or the safety and health of others (i.e. reporting a communicable disease).
- **Appointment reminders**: We may use or disclose your child's health information to provide you with an appointment reminder by telephone message, voicemail, letter or email with your written permission.

Disclosure: You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, with whom we shared it and why. We will include all the disclosures except for those about treatment, payment, health care operations and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Your authorization: In addition to our use and disclosure of yourchild's health information about your child for treatment, payment and healthcare operations, we may use your 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.

Marketing: We will not use your child's health information for marketing purposes or communications without your written authorization.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that your privacy rights may have been violated or you disagree with a decision we made regarding access to your child's health information or in response to a request you made in writing, please contact our privacy officer to make a complaint. You may also submit a written complaint to the U.S. Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

We support your right to the privacy of your child's health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Officer: Theresa Baumert, Director
Potential for Kids Inc (dba PlaySteps for Developing Kids)
849 Menlo Ave, Menlo Park, CA 94025
650-323-0805

ACKNOWLEDGEMENT OF
RECEIPT OF NOTICE OF PRIVACY POLICIES AND PRACTICES

Client Date

I,_____, have received a copy of this agency's Notice of Privacy Policies and Practices and authorize use and disclosure of my child's health information for treatment, payment and healthcare operations.

Print Name

Signature of parent or legal guardian Date

Signature of other parent, if required Date

Relationship to Client Date

Permission for Electronic Communication (Please initial after one of the choices below.)

Information sent by unencrypted email poses some risk that the content could be read by a third party. I have been apprised of this risk and agree to receive communications from PlaySteps for Developing Kids via email.
Initials _____ OR

The use of unencrypted e-mail is unacceptable and I request all confidential communications by mail, telephone or in-person.
Initials _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Policies and Practices, but acknowledgement could not be obtained because:

❑ *Individual refused to sign*
❑ *Communication barriers prohibited obtaining the acknowledgement*
❑ *Other (Please explain)*

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Informed Consent and Emergency Information

Movement and the use of moving equipment are integral to our therapy programs. We will make every effort to ensure your child's safety. We do want you to be aware, however, that it is possible for accidental injuries to occur in this environment. In addition, please be aware that physical contact with the therapist is common in our therapy programs.

Please provide us with emergency contact information, and sign below to indicate your informed consent to provide occupational therapy services for your child. If the parents are divorced, the signatures of both parents are required. Thank you.

_____ _____
Parent signature Date

_____ _____
Parent signature Date

Parents' names and contact information:

	Parent One	Parent Two
Name		
Home phone		
Work phone		
Cell phone		
Pager		

Emergency Contact Information, if parents cannot be reached

Name_____ Relationship _____

Phone Numbers _____

Does your child have any medical conditions or physical limitations/precautions?

_____

Any allergies? _____

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Permission to Exchange Confidential Information

If you file a claim with your insurance company for services provided at PlaySteps for Developing Kids, we may be required to provide information to the insurance company to assist in processing your claim. In addition, we may need to communicate with other professionals who work with your family. Your signature below gives us permission to provide information your insurance company requests; please add any other entities with whom we have your permission to share information about your child. Your signature also gives us permission for electronic transmission of information to these entities, such as through email. These above permissions can be revoked, in writing, at any time. It will otherwise be considered valid for five years.

Please indicate if you have any restrictions regarding forms of communication with other entities (such as insurance or other professionals): _____
_____

I hereby grant permission for the exchange of information about my child,

_____ _____
Child's Name Birthdate

between PlaySteps for Developing Kids and my medical insurance company, as well as the following individuals or agencies:

Name	Address and Phone Number
_____	_____
	_____
_____	_____
	_____
_____	_____
	_____
_____	_____

Are the child's parents divorced? Yes _____ No _____

If yes, both parents must sign below.

_____ _____ Parent's signature, date

_____ _____ Parent's signature, date

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Therapy Waitlist Form

All families: Please fill out this form and submit along with your registration packet. In the event that therapy is recommended, the date your Waitlist form is submitted will be the date your request is entered into the queue. This helps you receive an optimal time as soon as it becomes available.

Child's Name: _____ Date Request Submitted: _____

Birthdate: _____ Requested Start Date: _____

Please list all times that could work for your child as regular, weekly ongoing therapy times, in order of preference. Please be as specific as possible regarding days of week and range of starting/ending times. Our therapy sessions begin on the hour, 20 minutes after the hour, or 40 minutes after the hour.

_____
_____
_____
_____

While awaiting the requested therapy times, would you like to have your child temporarily scheduled for OT at another time? What time(s) would work temporarily?

_____
_____
_____

Date of occupational therapy evaluation: _____
Clinic where OT evaluation was/will be completed: _____

Any additional information: _____
_____
_____
_____

Parents' names, phone numbers, email: _____
_____
_____

Home address:

_____
_____

If we find a time that works temporarily for your child, you are welcome to stay on the waitlist for a time you prefer. Once you are satisfied with your therapy time, however, we will take your child off the waitlist. If you anticipate needing a schedule change, such as when your child's school schedule changes, please fill out a new form to request the change you need. We will assume you are keeping your therapy time unless you tell us otherwise. Please submit schedule change requests well in advance, as we honor these requests in the order received.

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Theresa Baumert, OTR/L, Director

The following documents (four pages) are **not** to be returned to PlaySteps with your registration forms. Pages 1-3 are included for your diagnosing professional to review and fill out (usually a primary care physician or psychologist). Considering Occupational Therapists do not diagnose, we ask that you request the proper codes from your diagnosing professional. We will then include them on your OT receipts to help you get reimbursed from your insurance company if you choose to submit claims. We've also provided (on page 4) helpful tips for submitting claims.

RE: Support of medical necessity for occupational therapy

The following may be helpful in wording a statement to satisfy the request from insurance companies for documentation of medical necessity. This information is provided to assist your physician, who will determine what he or she feels is appropriate for your child.

Suggested example: ____child's name_____ appears to have a neuromotor dysfunction of yet undefined etiology, in contrast to a developmental delay. He/she meets the criteria for a diagnosis of _____ (if no specific diagnosis, consider: F82 Specific Developmental Disorder of Motor Function, M62.81 Muscle Weakness, F50.9 Eating Disorder, Unspecified, or F93.9 Childhood Emotional Disorder, Unspecified [specific diagnosis to be determined by your pediatrician]). Occupational therapy is recommended for an hour once (or twice) weekly with the expectation of significant functional change. Progress should be reviewed in six months to determine the need for further intervention.

If your physician has any questions, please provide us with a release and we would be happy to speak with him/her directly.

PlaySteps for Developing Kids LLC
...let's play for a change

849 Menlo Ave, Menlo Park, CA 94025
Phone: 650-323-0805
Fax: 650-323-5262
www.play-steps.com
Theresa Baumert OTR/L, Director

Referral for Occupational Therapy

Dear Physician:

Your patient, _____ , is seeking occupational therapy services with us.

Although occupational therapists outside of a hospital are not required to work under a physician's referral, insurance companies often require documentation of a physician's referral for consideration of reimbursement. In order to facilitate processing of insurance claims, a physician's referral with diagnosis is highly recommended.

In the absence of other diagnoses, the following may best describe the difficulties experienced by many of the children seen in our clinic:

M62.81	Muscle Weakness (Generalized),
G70.2	Congenital and/or Developmental Myasthenia, or
F82	Specific Developmental Disorder of Motor Function

If the child has adequate coordination but has suspected sensory issues, some physicians use the diagnosis F93.9 Childhood Emotional Disorder, Unspecified or G96.9 Disorder of Central Nervous System, Unspecified.

Given a release of information, we would be happy to speak with you if there are questions about a diagnosis or our services.

Please fill out the attached, accompanying form and mail it to the address above, fax to 650.323.5262 or scan and email to theresa@play-steps.com.

Thank you for your support of this child and family.

Theresa Baumert and Staff

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Referral for Occupational Therapy

✓ Child's name: _____ ✓ Date of Birth: _____

✓ Occupational therapy for 60 minutes_____once a week _____twice a week

✓ Diagnosis/diagnoses: **If more than one diagnosis is used please indicate primary with an ***

___M62.81 Muscle Weakness (Generalized)

___G70.2 Congenital and/or Developmental Myasthenia

___F82 Specific Developmental Disorder of Motor Function

___R29.3 Abnormal Posture, Head Position

___G80.__ Cerebral Palsy; **specify type**: _____

___G96.9 Disorder of Nervous System, Unspecified

___R63.3 Feeding Difficulties, Oral Aversion

___F50.9 Eating Disorder, Unspecified

___F51.01 Primary Insomnia, Difficulty Initiating or Maintaining Sleep

___F84.0 Autistic Disorder; ___F84.2 Rett Syndrome; ___ F84.5 Asperger's Syndrome;
___F84.9 Pervasive Developmental Disorder, Unspecified

___Q99.2 Fragile X Syndrome

___Q90.9 Down Syndrome, Unspecified

___F90.1 ADHD, Predominantly Hyperactive Type;_____F90.2 ADHD, Combined Type;
___F90.0 ADHD, Predominantly Inattentive Type; ___ F90.9 ADHD, Unspecified Type

___F41.1 Generalized Anxiety Disorder; _____F41.9 Anxiety, Unspecified;
___F40.8 Other Phobic Anxiety Disorders

___F93.9 Childhood Emotional Disorder, Unspecified

___G96.9 Disorder of Central Nervous System, Unspecified

___ Other: _____ (specify)

✓ Physician name, address, and license number: _____

_____

I verify that the services requested are medically necessary for the above-named patient.

✓ *Signature:*_____✓ *Date:* _____

✓ *NPI #* _____

Please mail this form to the address above, fax to 650.323.5262, or email to theresa@play-steps.com. Thank you!

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Tips for Insurance Reimbursement

To facilitate insurance reimbursement to yourself for **outpatient occupational therapy**:

1) Insurance requires a physician referral/prescription, including a diagnosis. Please ask your child's doctor to write a referral for occupational therapy, including your child's diagnosis.

   If your child does not have a diagnosis, your doctor might consider ICD-10 codes:
   M62.8 Muscle Weakness,
   G70.2 Congenital and/or Developmental Myasthenia, or
   F82 Specific Developmental Disorder of Motor Function

   Currently, there is no "medically" recognized diagnosis for sensory integration deficits/ sensory processing disorders. If your child does not have motor or coordination difficulties and has primarily only sensory issues, a diagnosis your doctor may consider is: G96.9 Disorder of Central Nervous System, Unspecified

   Keep a copy (or original) of the doctor's referral with diagnosis(es). Send a copy to us for our records (insurance sometimes asks us for this information) and to insurance with your first claim.

2) An insurance company will not consider coverage for a service that has not occurred. Insurance receipts will be available to you once a service has taken place. If you have been charged a non-service fee such as for a late cancellation or a no show, your account will reflect your payment, but you will not have an insurance receipt.

3) Not all insurance policies cover "out of network, outpatient occupational therapy." You may want to talk to your insurance company about what YOUR POLICY covers. You do not need to provide them with any information other than the insured, member number, and diagnosis for them to tell you about your policy and your out of network deductible. Ask if pre-authorization is required, how many visits are allowed per calendar year, and what percentage of the fee per session is covered based on usual and customary charges.

4) Be cautious of any wording or information provided to the insurance company. Their interests are **medical**, not educational. Insurance will **not** cover treatment for difficulties in handwriting or school performance, nor will they consider sensory processing a medical issue. Appropriate information and terminology may include information such as low muscle tone, poor coordination, poor stability, frequent falls, limited strength, atypical development (not just delayed), safety risks, poor nutrition, etc. as appropriate for your child. These difficulties are resulting in "deficits" (instead of "delays") in gross motor, fine motor and self-care skill development.

If you have questions or concerns, please call us.