Occupational Therapy Intake and Initial Consent

CLIENT'S NAME_____ DATE OF BIRTH: _____

PARENT/GUARDIAN: _____ PHONE NUMBER: _____

PARENT/GUARDIAN: _____ PHONE NUMBER: _____

ADDRESS: _____

Initial Consent for Assessment & Treatment

Welcome to Thrive Therapy! The following material is provided to clarify the features of our program and ensure informed consent for participation of the above named individual (referred to as the "individual" throughout this document) in the assessment and subsequent intervention. Please review this material and initial each section and then provide your signature at the end of the document.

Overview of Services

Thrive Therapy is an agency serving individuals with disabilities and behavioral challenges in the state of Texas. We utilize behavior analysts and behavior assistants as independent contractors, providing supervision to ensure adherence to our model. Our services are designed to meet the unique needs of the individuals we serve and are subject to availability of qualified staff.

Thrive Therapy's goal is to produce lasting changes in the quality of life of the people we serve. Our approach involves conducting a comprehensive assessment to develop interventions in collaboration with family members, educators and direct services providers and others caring for the individual.

Expectations for Participation

To achieve the best possible outcomes for the individuals we serve, we believe it is essential to fully engage and empower families and other caretakers to carry interventions over into homes, schools, and communities. Instead of simply providing direct services, much of our work occurs in collaboration with others supporting the individual. As a partner in this process, you are agreeing to work closely with us and assume mutual responsibility for the individual's success. That means communicating with us regarding your goals, needs and challenges. It also means taking an active role in the process. Specifically, you agree to:

a. Communicate with members of the individual's support team (e.g., teachers, therapists)
b. Gather information to track the individual's behavior and circumstances surrounding it (e.g., data collection)
c. Help us to design a behavior support plan that is feasible for you and your family/agency
d. Actively participate in the coaching sessions to practice the support plan strategies
e. Make your best effort to implement the strategies on an ongoing basis, providing the behavior analyst feedback on the plan's effectiveness
f. Participate in evaluating our program by responding to caregiver surveys when administered

Parent Initials: _____

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Requested Schedule

At Thrive Therapy, we do our best to schedule services around the needs and preferences of our clients. Thrive Therapy's clinic is open 8:00-6:00pm. If you child qualifies for services, what times are you available to bring him/her for services?

Day	Start Time	End Time	In-Home or Clinic
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			

*These timings cannot be guaranteed, they serve as a means to identify the appropriate therapist/client fit.

Confidentiality

Maintaining strict confidentiality of client assessment and intervention information is a particular concern for Thrive Therapy staff. Thrive Therapy will maintain records at both 2825 Valley View Lane #100 Famers Branch, TX 75234 and electronically.

Records may only be accessed by authorized personnel and will be protected via locked file cabinets and encrypted passwords on computers. No information related to an individual who is receiving services, either verbal or written, will be released to other agencies or individuals without the express written consent of the individual's legal guardian.

By law, however, the rules of confidentiality do not pertain under the following conditions:

1. If abuse or neglect of a minor, disabled, or elderly person is reported or suspected, the professional involved is required to report it to the local law enforcement office or child welfare office for investigation.
2. If, during the course of services, the professional involved receives information that someone's life is in danger, that professional has the duty to warn the potential victim.
3. If our records and staff testimony are subpoenaed by court order, we are required to produce records or appear in court to answer questions regarding the individual.
4. If you choose to break confidentiality by sharing private information through conversations or an unsecured communication medium (e.g., email, telephone), Thrive Therapy cannot be held liable for the outcome.

Parent Initials: _____

Payment for Services

Payment for our services is expected to occur in a timely manner. If paying privately for services, a written agreement the fees and billing schedule will be established. Insurance coverage is subject to eligibility and availability of funds (e.g., policy lapses and deductible renewal). Once our services begin, if at any time the client becomes ineligible for insurance, it is your responsibility to notify Thrive Therapy to postpone or cancel services until eligibility has been restored. Hours billed to insurance that are not reimbursed due to ineligibility will be directly billed to the parent/guardian/individual and will become their responsibility. Payment plans are available.

It is inappropriate for our independent contractors to accept money or gifts from clients. Therefore, Thrive Therapy strongly discourages parents/guardians/individuals from offering behavior analysts or behavior assistants any additional rewards, including, but not limited to cash, gift cards, gas money, tickets or admission to events, or any other costly items.

Parent Initials: _____

Crisis Management

Given the nature of the challenges individuals who participate in our services face, it is not uncommon for an individual to engage in behavior that puts him/her or others at risk. If this occurs, the crisis will be managed using the least intrusive and safest strategies to curtail the behavior. Thrive Therapy makes every effort to avoid provoking this type of behavior unnecessarily and to respond quickly to address problems as soon as they arise (e.g., through prompting communication, presenting choices or assistance, clarifying expectations, or using redirection). If the individual becomes aggressive or self-injurious, these behaviors may be managed by blocking strikes, removing the person or others, changing the surroundings, or restraining the individual briefly using an approved crisis management procedure. If the caregivers and staff are unable to manage the behavior safely, they will call 911 and/or seek assistance from another Thrive Therapy professional. If medical attention is required, the parent/guardian/caregiver will need to provide transportation. Specific crisis management procedures will be incorporated into the individual's behavior support plan.

Parent Initials: _____

Rights of Our Clients

Individuals with disabilities (and behavioral challenges) have the same rights as everyone else. Thrive Therapy embraces the Bill of Rights for the Developmentally Disabled and does everything in its power to uphold these rights. These rights specify that individuals and their families must be treated with dignity and that behavioral procedures must be explained in user-friendly terms. Individuals also have the right to be free from abuse. If someone suspects that an individual is being abused or neglected, this should be reported to the abuse hotline at the following number: 1-800-962-2873

Parent Initials: _____

Occupational Therapy In-Take

Today's Date: _____

Child's Name: _____ Date of Birth: _____

Parent's Name(s): _____

Primary Contact Number: _____

Parent email address: _____

Address: _____

Previous evaluations (list): _____

Does your child have any diagnosis? Please specify and provide date of diagnosis:
_____

Who diagnosed? (PCP, school district, etc)_____

List any therapies your child has had/is currently having:
_____
_____

Describe present problem(s):
_____
_____
_____

What is your child's reaction to the problem(s):
_____
_____
_____

How does the family react to the problem(s):
_____
_____
_____

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Birth and Medical History

Name of pediatrician: _____
Office phone number: _____

Did you carry child full term? Yes / No If no, how many weeks: _____

Any conditions that may have complicated pregnancy or birth?:_____
_____

Are there any current medical concerns/injuries:
_____
_____
_____

Are immunizations current? Yes / No If not, please specify why: _
_____
_____

Current general health: _____

Medications: _____

Vision problems: _____ Hearing difficulties: _____

Other medical history:
_____
_____
_____

Language Development

Language(s) spoken at home:_____

How many words can your child say? (list if less than 15):
_____
_____

What is the length (in words) of your child's sentences: _____

Does your child have difficulty understanding you (describe):
_____

Social Development

Name and age of sibling(s): _____

Other adults living in the home: _____

How does your child handle frustration: _____
Conflict: _____ Separation: _____

Favorite places: _____ People: _____ Toys: _
_____ Snacks: _____
Activities: _____ TV Programs: _____

What motivates your child the most?
_____

School History

Child's current school and grade: _____

What time does your child get out of school: _____

Receiving special education at school (please list all):
_____

Any therapy services outside of school:
_____

What are your goals for your child's occupational therapy abilities?
_____
_____
_____
_____

What are your primary concerns? (e.g. social, behavioral, academic, sensory, language, motor skills, etc.)
_____
_____
_____
_____

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Motor Milestones

	< 5 mo	5-9 mo	10-14 mo	15-17 mo	18-24 mo	25 +
Rolled						
Sat Independently						
Crawled						
Stood						
Walked Independently						
Fed Self						

Is your child able to perform the following self-care activities?

	YES	NO
Socks on and off		
Shoes on and off		
Pants on and off		
Shirt on and off		
Buckle/unbuckle		
Zip/unzip		
Tie/Untie		

Please complete this form and return with other applicable forms to the office prior to the date of assessment. Thank you!