T4K Office Use Only

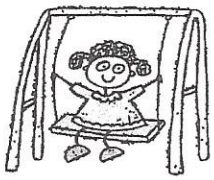
OT ___ ST____ PT_____

TULSA CLINIC

SAPULPA CLINIC

Clinic____

Other:_____



## Client Intake Information – Therapy 4 Kids

Client's Name: _____ Date of Birth: _____
Diagnosis: _____
Child lives with: _____ Client's Sex: ___M ____F

## Parent/ Guardian Information:

Responsible party: Father: _____ Mother: _____ Other: _____
Name: _____
Street Address: _____
State: _____ Zip _____
Home Phone: _____
Cell Phone: _____
Emergency contact: _____ Phone: _____

## Insurance Information:

The client, _____, does not have private insurance. He/She receives only Medicaid services.

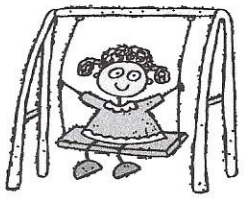
Signature: _____

If the client has insurance please furnish a copy (front and back) of the insurance card(s) for all medical benefit plans applicable to your child (insurance, Medicaid).

Was problem caused by an accident, illness, or injury? ____ yes ___ No If yes, date of occurrence: _____
Primary Care Physician (PCP): _____
Address: _____
Phone: _____ Fax: _____
Date last seen by PCP: _____

Insured's name: _____ DOB: _____
SSN: _____ Insurance Company: _____
Claims Address:
_____
_____
Network Name: _____ ID# _____
Group # _____ Eligibility Phone: _____
Benefits Phone: _____ Co-Pay: _____

**Therapy 4 Kids, Inc.**
5110 S. Yale Ave. Ste102
Tulsa, Ok. 74135
Ph: (918)492-2386
Fax: (918) 645-8686



## PARENT QUESTIONNAIRE

Date: _____ Referred by: _____

Child's name: _____ Home Phone: _____
Street: _____ Date of birth: _____
City: _____ State: _____ Zip: _____
School: _____ Grade: _____ Teacher: _____

**REASON FOR REFERRAL:**
Parent concerns: please list all concerns with those of greatest importance first and date problem began:_____
_____
_____
_____
_____
_____
Attempted Parental Solutions to Concerns:
_____
_____
_____
_____

Teacher Concerns and attempted solutions: please list all concerns with those of greatest importance first (also include date problem began):
_____
_____
_____
_____
_____

**PLEASE LIST ALL FOOD AND DRUG ALLERGIES:**_____
_____

**IN CASE OF EMERGENCY CONTACT:** _____ PHONE_____

**PLEASE LIST ALL MEDICATIONS CLIENT IS TAKING NOW:**

| medication | dosage | condition requiring | doctor who prescribed | phone # of prescribing doctor | date started |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**List schools child previously attended and dates:**

| School | City | Grade Level | Dates |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Mother's Name: _____ Marital status: _____
Street: _____ City: _____ State: ___ Zip: _____
Home Phone: _____ Work Phone: _____ Cel: _____
Level of Education: _____ Profession: _____
Mother's Employer: _____ Social Security # : _____
Mother's age at time of birth: _____

Father's Name: _____ Marital status: _____
Street: _____ City: _____ State: ___ Zip: _____
Home Phone: _____ Work Phone: _____ Cel: _____
Level of Education: _____ Profession: _____
Father's Employer: _____ Social Security # : _____
Father's age at time of birth: _____

**FAMILY MEMBERS**:

**Please list all immediate family members, including parent(s) and siblings, as well as other people that are living in the household of child to be evaluated**

| Name | birth date | age | relationship to child | highest grade completed | in/out of home |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Please tell us anything you think might be important for us to know about your child and your family or any particular problem that preceded the client's current difficulty and might have been associated with its onset.**

_____

_____

_____

_____

**Please check any therapies for which the client has had previously or has written medical orders for at this time**:

Psychological therapy _____ Family therapy _____ Group Therapy _____

Hospitalization _____ Special diet _____ Occupational Therapy _____

Physical Therapy _____ Speech/ Lang. Therapy ____ Vision Therapy _____

Auditory training _____ Other _____

Please explain any checked items in more detail _____

_____

**HEARING AND VISION:**

Hearing Screening date: _____

Pass _____ Fail _____ Aided _____

Vision Screening date: _____

Pass _____ Fail _____ Lenses _____

Doctor: _____

_____

**PRENATAL HISTORY**:

**What was the mother's condition while pregnant with this child? Please check all that apply**:

Do not know _____
Premature contractions _____
Gestational diabetes ____
Anemia _____
Allergies _____
Emotional strain _____
Cardiac infection _____
Convulsions ____
Excess nausea _____
Toxemia _____
Smoked less than 1 pack per day _____
Drank alcohol infrequently _____
Used illegal drugs _____

Bleeding _____
Edema (swelling): _____
Hypertension (high blood pressure): _____
Rubella _____
Serious Injury _____
Viral Infection _____
High fever ____
Surgery ___
Amniotic fluid loss ____
Normal, no health problems _____
Smoked more than one pack a day _____
Drank alcohol frequently _____
Took prescription drugs
List: _____
_____

Other: _____

**PERINATAL HISTORY**:

**What were the conditions of the child's birth? Please check all that apply.**

Do not know _____
Normal, no unusual problems _____
Premature birth _____ _____wks gestation
Mother ill at time of birth _____
Planned Cesarean delivery _____
Rh factor problems _____
General anesthesia (mother unconscious) _____
Cord around neck _____
Did not breathe at first _____
Jaundice _____
Infant required feeding tube _____
Infant required incubator _____
Infant had congenital defects _____
Birth weight: _____ lbs. _____oz.

Full term pregnancy _____
Long Labor _____
Breech birth _____
Emergency Cesarean delivery _____
Local anesthesia (epidural) _____
Use of forceps _____
Slow heartbeat _____
Infant was considered low birth weight ____
Infant required oxygen _____
Infant required blood transfusion _____
Infant was limp/floppy _____
Infant with fever _____
Other _____

Was the infant bottle fed _____ Breast fed _____ Breast with supplement _____
Any feeding complications? _____

**POST NATAL HISTORY**:

**Please check all that did or do apply.**

Almost always crying _____
Extremely active _____
Inactive and quiet, but alert _____
Sociable _____
Alert _____
Playful _____
Unhappy _____
Excessive sleeper _____
Do Not know _____
Reached out to be picked up _____
Wanted to be held a great deal _____
Difficulty falling asleep _____
Sleep little, but seems comfortable _____
Shows signs of physical activity during sleep ____
Frequent nightmares _____
Often sleeps in parents bed _____
Food allergies _____
Difficulty swallowing _____
Colic _____
Dislikes foods of certain textures _____
Chokes of food _____
Ear infections _____

Difficult to comfort _____
Inactive, sluggish _____
Calm _____
Happy _____
Affectionate _____
Angry _____
Withdrawn _____
Fearful _____
Cried occasionally _____
Did not want to be held _____
Wanted to be held sometimes _____
Difficult to awaken _____
Wakes up frequently at night _____
Sleep walker _____
Needs parents presence to fall asleep ____
Poor appetite _____
Difficulty sucking _____
Reflux _____
Refuses most food _____
Wanders from table while eating _____
Spits up frequently _____

Other: _____

**Were there problems in toilet training**?

_____ mild
_____ moderate problems
_____ severe problems

At what age achieved? _____ daytime
_____ night time

**Has the child ever been seen in the emergency room?** _____ If yes, please explain and give dates. _____

_____

**Motor Milestones:** At what age did the child accomplish the following:

Sit alone _____
Walk _____
Ride a tricycle _____

Crawl _____
Go downstairs _____
Ride a 2 wheeled bike without training wheels _____

Comments: _____

**Circle Y (yes) N (no) or S (sometimes) as the statements below relates to your child.**

| | | | |
|---|---|---|---|
| **Gross Motor and Fine Motor:** | | | |
| 1. Difficulty riding a riding toy, with feet pushing or propelling | Y | N | S |
| 2. Difficulty pumping self on swing | Y | N | S |
| 3. Difficulty learning how to ride a bike | Y | N | S |
| 4. Dislikes coloring or paper and pencil tasks | Y | N | S |
| 5. Dislikes playing with puzzles or becomes easily frustrated | Y | N | S |
| 6. Difficulty playing with small manipulative toys (ie. legos, etc..) | Y | N | S |
| 7. Difficulty using scissors or learning how to use scissors | Y | N | S |
| 8. Seems weaker or tires more easily than other children his age | Y | N | S |
| 9. Appears stiff, awkward, or clumsy in movement | Y | N | S |
| 10.Seems to have great difficulty learning new motor tasks | Y | N | S |
| 11. Difficulty catching a ball | Y | N | S |
| 12. Difficulty kicking a ball | Y | N | S |
| 13. Difficulty learning how to swim | Y | N | S |
| **Self-Help Skills**: | | | |
| 1. Difficulty with the use of a spoon (messy eater) | Y | N | S |
| 2. Difficulty cutting with a knife | Y | N | S |
| 3. Difficulty with dressing himself | Y | N | S |
| 4. Difficulty with clothing fasteners (buttons, zippers) | Y | N | S |
| 5. Difficulty tying his shoes | Y | N | S |
| 6. Difficulty brushing teeth | Y | N | S |
| 7. Difficulty making a simple sandwich | Y | N | S |
| 8. Difficulty completing chores | Y | N | S |
| 9. Difficulty making his bed | Y | N | S |
| 10. Difficulty taking a bath or shower (washing himself) | Y | N | S |
| 11. Difficulty washing his hair | Y | N | S |
| **Movement and Balance:** | | | |
| 1. Gets car sick frequently | Y | N | S |
| 2. Gets nauseated or vomits from other movement experiences (ie. Swings, playground, merry-go-round) | Y | N | S |
| 3. Is unable to give adequate warning about feeling of nausea | Y | N | S |
| 4. Seeks quantities of twirling or spinning | Y | N | S |
| 5. Seeks quantities of stimulation on amusement park rides/swings | Y | N | S |
| 6. Hesitates to climb or play on playground equipment | Y | N | S |
| 7. Has trouble or hesitancy in learning to climb or descend stairs | Y | N | S |
| 8. Dislikes being lifted up and gently tossed in the air by parent | Y | N | S |
| 9. Did not or does not like being placed on his stomach or back as infant. | Y | N | S |

| | | | |
|---|---|---|---|
| 10. Rocks himself when stressed | Y | N | S |
| 11. Period of crawling absent or very brief | Y | N | S |
| 12. Walks on toes, now or in the past | Y | N | S |
| 13. Is always on the "go" or constantly moving | Y | N | S |
| 14. Trips or falls frequently | Y | N | S |
| **Touch:** | | | |
| 1. Seems unaware of being touched | Y | N | S |
| 2. Seems unaware of being hurt/pain in comparison to others | Y | N | S |
| 3. Seems overly sensitive to being touched, pulls away from light touch | Y | N | S |
| 4. Seems excessively ticklish or strong dislike to being tickled | Y | N | S |
| 5. Dislikes the feeling of certain clothing or tags | Y | N | S |
| 6. Resists wearing short sleeved shirts or short pants | Y | N | S |
| 7. Has difficulty transitioning clothes to reflect seasons (ie. going from wearing pants and long sleeves to shorts or visa versa) | Y | N | S |
| 8. Continues to examine objects by putting them in the mouth (past age 1.5 years) | Y | N | S |
| 9. Dislikes being cuddled or hugged, unless on child's terms | Y | N | S |
| 10. Avoids putting hands in messy substances | Y | N | S |
| 11. Seems unaware that face or hands are messy | Y | N | S |
| 12. Strongly dislikes hair cutting or washing | Y | N | S |
| 13. Strongly dislikes bath or shower time | Y | N | S |
| 14. Very sensitive to water temperature (it must be "just right" ) | Y | N | S |
| 15. Strongly dislikes toe or finger nail cutting | Y | N | S |
| 16. Pinches, bites, or otherwise hurts himself | Y | N | S |
| 17. Frequently bangs head repeatedly | Y | N | S |
| 18. Crawled with fisted hands | Y | N | S |
| 19. Seems overly sensitive to slight bumps or scrapes | Y | N | S |
| 20. Tendency to touch things constantly | Y | N | S |
| 21. Frequently pushes, bites or hits other children | Y | N | S |
| **Auditory/ Language**: | | | |
| 1. Has or has had repeated ear infections | Y | N | S |
| 2. Particularly distracted by sounds, seeming to hear sounds that go unnoticed by others | Y | N | S |
| 3. Often fails to listen or pay attention to what is said to him | Y | N | S |
| 4. Is overly sensitive to mildly loud noises | Y | N | S |
| 5. Frequently covers ears when sounds are loud | Y | N | S |
| 6. Is afraid of some noises | Y | N | S |
| 7. Enjoys hearing his voice echo or make loud noises | Y | N | S |
| 8. History of delayed speech development | Y | N | S |
| 9. Is difficult to understand | Y | N | S |
| 10. Stammers or stutters | Y | N | S |
| 11. Speaks in incomplete sentences | Y | N | S |
| 12. Seems confused as to the location or direction of sound | Y | N | S |

| | | | |
|---|---|---|---|
| 13. Has difficulty paying attention in proximity to other noises | Y | N | S |
| 14. Does not seem to understand what is said to him | Y | N | S |
| 15. Talks constantly | Y | N | S |
| 16. Has a diagnosed hearing loss | Y | N | S |
| **Emotional:** | | | |
| 1. Does not accept changes in routine easily | Y | N | S |
| 2. Becomes easily frustrated | Y | N | S |
| 3. Apt to be impulsive, heedless, accident-prone | Y | N | S |
| 4. Marked mood variations, tendency to outbursts or tantrums | Y | N | S |
| 5. Tends to withdraw from groups, plays on the outskirts | Y | N | S |
| 6. Seems to do things the hard way | Y | N | S |
| 7. Changes activities frequently | Y | N | S |
| 8. Frequently breaks toys or is overly rough on his toys | Y | N | S |
| 9. Is impatient, cannot wait | Y | N | S |
| 10. Cannot tolerate frustration | Y | N | S |
| 11. Hums or taps fingers | Y | N | S |
| 12. Does not finish what is started | Y | N | S |
| 13. Takes a long time to settle down | Y | N | S |
| 14. Insists that bedroom/toys must be in precise order | Y | N | S |
| 15. Is generally disorganized | Y | N | S |
| 16. Is unable to put things in order | Y | N | S |
| 17. Cannot sit through a board game | Y | N | S |
| 18. Does things without thinking | Y | N | S |
| 19. Cannot play quietly for 20 minutes | Y | N | S |
| 20. Is always on the go | Y | N | S |
| 21. Runs rather than walks | Y | N | S |
| 22. Fidgets or squirms | Y | N | S |
| 23. Cannot keep hands to himself | Y | N | S |
| 24. Is difficult to take to visit friends/ relatives/ shopping | Y | N | S |
| 25. Resists changes in routine | Y | N | S |
| 26. Is difficult to leave with a babysitter | Y | N | S |
| 27. Is overly cautious | Y | N | S |
| 28. Cries for the slightest reason | Y | N | S |
| 29. Forgets social expectations | Y | N | S |
| 30. Cannot tolerate noisy, busy places | Y | N | S |
| 31. Needs a calm, quiet atmosphere in order to concentrate | Y | N | S |
| 32. Does sloppy work in spite of effort | Y | N | S |
| 33. Ignores social rules of modesty | Y | N | S |
| 34. Has no guilt for wrongdoing | Y | N | S |
| 35. Believes rules apply only to others | Y | N | S |
| 36. Does not seem to learn from experience | Y | N | S |
| 37. Cannot tell right from wrong | Y | N | S |
| 38. Always has an excuse | Y | N | S |

| | | | |
|---|---|---|---|
| 39. Complains of unfair treatment | Y | N | S |
| 40. Has poor self-image, feels worthless | Y | N | S |
| 41. Is overly concerned about performance | Y | N | S |
| 42. Is irritable | Y | N | S |
| 43. Has short fuse, explodes at any little thing | Y | N | S |
| 44. Has hurt someone such that medical attention was necessary | Y | N | S |
| 45. Is insensitive to feelings of others | Y | N | S |
| 46. Resists authority | Y | N | S |
| 47. Is defiant/belligerent when disciplined | Y | N | S |
| 48. Purposely does the opposite of what is told | Y | N | S |
| 49. Makes up untruths | Y | N | S |
| 50. Picks only on people smaller that self | Y | N | S |
| 51. Cannot be trusted alone | Y | N | S |
| 52. Wants friends but is rejected by others | Y | N | S |
| 53. Has a few friends, seems disliked | Y | N | S |
| 54. Has no close friends | Y | N | S |
| 55. Prefers to play with older children | Y | N | S |
| 56. Prefers to play with adults | Y | N | S |
| 57. Prefers to play with younger children | Y | N | S |
| 58. Is physically rough with others | Y | N | S |
| 59. Is excessively bossy with peers | Y | N | S |
| 60. Gets into fights because of frustration | Y | N | S |
| 61. Is overly submissive, easily led | Y | N | S |
| 62. Has to be the leader | Y | N | S |
| 63. Resists sharing | Y | N | S |
| 64. Assumes the role of the clown | Y | N | S |
| 65. Appears depressed, sad, gloomy | Y | N | S |
| **Academic Area**: | | | |
| 1. Difficulty using scissors | Y | N | S |
| 2. Difficulty with fine hand work (puzzles, models, etc.) | Y | N | S |
| 3. Difficulty recognizing letters | Y | N | S |
| 4. Difficulty recognizing numbers | Y | N | S |
| 5. Difficulty with drawing or coloring tasks | Y | N | S |
| 6. Difficulty with writing letters/numbers/ words neatly | Y | N | S |
| 7. Difficulty learning to count money | Y | N | S |
| 8. Difficulty telling time on a regular clock | Y | N | S |

Is your child currently receiving any special services or assistance at school (including private tutors, and therapy)? If yes, please explain.

_____

_____

# THERAPY 4 KIDS, INC.

## Permission to Photograph or Video Record Your Child and Animal Assisted Activity/ Intervention Participation Form

### Photograph or Video Record

**Over the years we have found it very useful to have a photograph or make video recordings of children seen in our therapy sessions. These are made for several different purposes.**

1. **Identification**: These photographs are taken during the first visit and are placed in the chart for the purpose of identification within Therapy 4 Kids. These photos are kept in the chart and are not released with other records. They will be destroyed when the record is destroyed.
2. **Classroom or Workshop training**- The therapists sometimes participate in workshops or in-services for instruction of other therapists. It is often very helpful in teaching to have a visual aide (picture or video clip) demonstrating a particular therapy technique. All effort is taken to not reveal the child's real identity.
3. **Marketing**: These photographs are taken of children participating in therapy to illustrate what we do in therapy. No identities are ever revealed on the children or specifics to their diagnosis.

**I give my permission for my child to be photographed or video recorded for the following purposes indicated by my initials:**

☐ Identification ☐ Classroom Training/Education ☐ Marketing

### Animal Assisted Activity/ Intervention Participation

**Therapy 4 Kids has a Trained Facility Dog which participates in Greeting children or Therapy sessions with a Trained Handler on site.**

☐ **Yes**, My child may participate in greetings and or therapy sessions with a Facility/ Therapy Dog both in Animal Assisted Activity and Intervention Treatment Methods.

☐ **No**, My child may NOT participate in greetings and or therapy sessions with a Facility/ Therapy Dog both in Animal Assisted Activity and Intervention Treatment Methods. **NOTIFY YOUR THERAPIST AND STAFF VERBALLY IF YOU CHOOSE NO.**

**If NO please list Reason:** Allergy, etc.

---

**Please Sign Below:**

_____
Client Name Parent Name

_____
Parent/ Legal Guardian Signature Date

_____
Witness Date

# T 4 Kids, Inc. Therapy Business Policies:

It has been our experience that therapy is most effective when expectations regarding fees, billing, insurance, reimbursement, and cancellation policies are understood by all parties in advance. Please review the information below, and feel free to ask if there are any questions.

Fees: Initial evaluations and therapy visits are generally 60 minutes in length. Shorter treatment sessions may be recommended based on the age of the child or tolerance level for intervention.

| | |
|---|---|
| Initial evaluation (60 minutes) | 69.16 |
| Standard treatment session (55 minutes) | 106.20 |
| Shortened treatment session (40 minutes) | 79.65 |

**Payment Policies**:
Therapy 4 Kids, Inc. will gladly submit all therapy treatment claims to Sooner Care for processing. I understand that I am fully responsible for payment on my child's account should Sooner Care decline payment. I agree to pay fully for all services at the conclusion of each session. There is a $20.00 fee for all returned checks. We reserve the right to retain a collection agency or attorney to collect unpaid fees after termination of services if a former client fails to make a reasonable effort to take care of any outstanding balance. Checks are to be made out to Therapy 4 Kids, Inc..

**Appointment Policy:**
I understand that when an appointment is scheduled for my child, a specific period of time is set aside just for my child. If I am late, my session cannot be extended beyond the time reserved for me, because it would infringe on the next client's appointment time. I understand that I will be charged the full fee. Additionally, if a child misses his/her therapy appointment three times, without prior notification, then discharge from services may result.

**Cancellation Policy**:
If you cannot keep an appointment, please notify our office or therapist at least 24 hours in advance so that we can reschedule someone else for the time that has been reserved for you. Unless we are able to reschedule with shorter notice, the regular fee may be charged for appointments missed without notice or cancelled with less than 24 hours notice. There is no charge for appointments cancelled due to illness or emergency if the office/ therapist is notified prior to the scheduled appointment time.

**Release Of Information:**
Please indicate anyone (school, physician, etc..) with whom you would like us to release or exchange information.

# Therapy 4 Kids, Inc.

## Notice of privacy Practices

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

This practice uses and discloses health information about you from treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. This notice describes our privacy practices and your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. You can request a copy of this notice at any time. For more information about this notice or our privacy practices and policies, please contact the person listed at the end of this packet.

### Treatment, Payment, Health Care Operations:

#### Treatment

We are permitted to use and disclose your medical information to those involved in your treatment. For example, the Occupational Therapists and Speech Language Therapists working within this practice are specialists. When we provide treatment, we may request that your primary care physician share your medical information with us. Also, we may provide our primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

#### Payment

We are permitted to use and disclose your medical information to bill and collect payment for the services provided to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. The form will contain medical information, such as a description of the medical service provided to you, that your insurer or HMO needs to approve payment to us.

#### Health Care Operations

We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may engage the services of a professional or "Business Associate" to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law. Also, we may ask another physician to review this practice's charts and medical records to evaluate our performance so that we may ensure that only the best health care is provided by this practice. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and services we offer. We may also send you information about products or services that we believe would be beneficial to you. You may contact our Privacy Officer to request these materials not be sent to you.

#### Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

#### Questions and Contact Person for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:
**Therapy 4 Kids, Inc., 5110 South Yale, Suite 103, Tulsa, Oklahoma 74135**
**Privacy Officer: Kelly Godfrey; This** notice is effective on the following date: 8-1-08
We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.

## Acknowledgement of Review of Notice of Privacy Practices:

I have reviewed the office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Client or Personal Representative Date

_____ _____

Name of Client or Personal Representative Relationship to Client

## Therapy 4 Kids, Inc.
## Release of Information:

**Release Of Information:**
Please indicate anyone (school, physician, etc..) with whom you would like us to release or exchange information.

| Name: | Relationship: |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

I do NOT wish to have my child's information shared with:

_____

_____

**Insurance:**
Currently we are providers for BCBS of OK & UHC and will file that insurance company on your behalf. If your insurance carrier contacts us requesting information on the clients file:

_____ Do not release any information
_____ Release only dates of appointments, clinician's names and diagnostic codes.
_____ Release any information requested by my insurance company.

Client's Name: _____ DOB: _____

Responsible Party (please print): _____

Signature of Responsible Party: _____

Witness: _____ Date: _____

**STATE OF OKLAHOMA**
**Oklahoma Health Care Authority**

# Parental Consent Form

**Member Name:** _____
**Member RID #:** _____
**Member Diagnosis:** _____

**I** _____ (print name of parent/legal guardian) **hereby authorize** _____ (print name of provider) **to evaluate, as well as provide any subsequent treatment based on the evaluation results for Physical Therapy, Occupational Therapy and/or Speech Therapy** (circle all services that apply) **for child named above.**

_____
**Signature of Parent/Legal Guardian**

_____
**Date Signed by Parent/Legal Guardian**

_____
**Relationship to Member**

_____
**Signature of Therapist or Representative of Therapy Group**

_____
**Date Signed by Provider**

******Please Note Form must be completed in its entirety or will be considered incomplete and will not be accepted******