Skills on the Hill
PEDIATRIC OCCUPATIONAL THERAPY

CAPITOL HILL OFFICE
405 8th Street NE
Washington, DC 20002
202.544.5439 phone
202.379.1797 fax

ARLINGTON OFFICE
3508 Lee Highway, Suite 100
Arlington, VA 22207
phone 703.243.4601
fax 202.379.1797

INITIAL PAPERWORK CHECKLIST:

- ☐ **Insurance Verification of Benefits –** must be completed and submitted following scheduling of appointment to Skills on the Hill's Billing Office by Fax: **301-668-7008** or Email: **skills@hspmd.com**

Remaining documents MUST be returned to Skills on the Hill at least one week prior to the scheduled evaluation or first therapy appointment. They can be scanned and emailed to info@skillsonthehill.com or faxed to 202-379-1797

- ☐ **Intake Information (Medical and Developmental History, etc.)**
- ☐ **Special Consent & Policy Forms**
  - **Consent for Services**
  - **Confidentiality Policy**
  - **Authorization for Release of Information**
  - **Cancellation & Attendance Policy**
- ☐ **Payment Policy & Insurance**
  - **Fee Schedule**
- ☐ **HIPAA**
- ☐ **Questionnaires for teachers / caregivers regarding sensory processing (separate documents – will be sent via email)**
- ☐ **Feeding Questionnaire (if feeding evaluation is recommended)**

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INSURANCE VERIFICATION OF BENEFITS

(This information is needed so benefits for therapy can be verified prior to the start of treatment)

Please send this information to: Fax: **301-668-7008** Email: **skills@hspmd.com**

Main Concern / Diagnosis: _____

Child's Name: _____ Date of Birth: _____

Address: _____

Your name to discuss benefits: _____

Your relationship to the child: _____

Best number to reach you: _____ mobile ☐ home ☐ work ☐

Email: _____

Does your child have secondary insurance? ☐ YES ☐ NO

Primary Insurance Company Name: _____

Subscriber name: _____ Subscriber Date of Birth _____
(Required) (Required)

Insurance ID Number: _____ Group#_____

Claims mailing address: _____

Claims contact Tel. # _____

Secondary Insurance Company Name: _____

Subscriber name: _____ Date of Birth _____
(Required) (Required)

Insurance ID Number: _____ Group#_____

Claims mailing address: _____

Claims contact Tel. # _____

Comments:

405 8th St, NE Ste 301
Washington, DC 20002
202.544.5439

Benefits Verification
202.424.2718

3508 Lee Highway Ste 100
Arlington, VA 22207
703.243.4601

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INTAKE INFORMATION

Date: _____

Child's Name: _____ Date of Birth: _____

Parents/Guardian #1: _____#2_____

Address Parent/Guardian #1_____

Home Phone: _____

Cell Phone(s): _____

Work Phone(s):_____

Email: _____

Address Parent/Guardian #2_____

Home Phone: _____

Cell Phone(s): _____

Work Phone(s):_____

Parents/Guardians' Profession(s):_____

Email:__ _____

Child Care Provider's Name: _____ Phone: _____

Sibling(s) Names and Ages: _____

Emergency Contact (name, phone): _____

Child's School: _____ Grade level: _____

School Contact Person: _____ School Phone: _____

Conditions/allergies which may require immediate or emergency care and treatment _____

_____

Please list medications taken on a regular basis _____

Does your child wear glasses/corrective lenses? _____

If my child becomes ill or involved in an accident and I cannot be contacted, I authorize the

following hospital or my child's physician to give emergency medical treatment required:

Hospital/Doctor_____

*** DEVELOPMENTAL HISTORY ***

PRENATAL HISTORY

Pregnancy: # of Weeks_____ Normal/Problems (describe)_____
_____

Birth Weight: _____ Apgar Score: _____ Labor: Normal/Induced

Special Considerations: Cesarean _____ Premature _____Breech_____

Child Rotated _____Cord Around Neck _____Other_____

Hospital Stay: Mother _____Child_____

If child was adopted, please give as much information as possible about the child's biological mother and family history. _____
_____

DEVELOPMENTAL MILESTONES:

At what age did your child: sit up without support _____crawl_____

walk_____ run _____use words _____speak in sentences _____

drink from a cup_____ use spoon, fork, knife _____dress self_____

*** MEDICAL HISTORY ***

Does your child have any allergies? _____

Is your child currently taking any medications regularly or as needed? _____
_____

Does your child have history of ear infections? _____

Has your child had his/her hearing tested? Results? _____

Has your child had a visual exam? If so, when and what were the results? _____
_____

Has your child received a medical diagnosis/diagnoses from any other health care professional(s)?
_____

Is your child currently receiving any other special services through school or privately? (physical therapy, speech therapy, psychology, tutoring - please list names of other professionals)

_____

_____

Who is your child's pediatrician? _____

*** EDUCATIONAL HISTORY ***

What is your child's current grade? _____Teacher's Name_____

What school does he/she attend? _____

Please list other school attended. _____

Does your child have an Individualized Education Plan (IEP)? _____

Has your child's teacher reported any concerns? _____

_____

_____

*** BEHAVIOR / SOCIAL ***

Describe your child's social interaction with other children. _____

_____

_____

_____

Describe your child's tolerance for challenging or frustrating tasks. _____

_____

_____

_____

How does your child do when making transitions between activities, environments, or when there are unexpected changes in plans/expectations? _____

_____

_____

Does your child tend to play alone, with other children, or performs both equally?

_____

_____

*** ATTENTION / SELF-REGULATION ***

Does your child have a difficult time calming down to go to sleep or waking up in the morning? If so, please explain. _____

_____

Is your child irritable at predictable times of the day? If so, what events trigger this and when does it occur? _____

_____

Does your child seem happier or more cooperative at predictable times of the day? Please describe.

_____

_____

Does your child exhibit any impulsiveness, aggression, or immaturity more than other children his/her age? If so, please explain. _____
_____

Describe your child's ability to attend to activities (e.g. responding to his/her name or a question in a timely manner, table top tasks -vs- gross motor activity -vs- homework). _____
_____

*** SELF-CARE / DAILY ROUTINES ***

Please describe your child's eating habits (include # of meals, # of snacks, food likes/dislikes.
_____
_____

If your child is experiencing feeding problems, please provide additional information. (e.g. foods you child eats regularly) _____
_____

Foods your child used to eat but no longer eats. _____
_____

Are there sensitivities to taste? Explain. _____
_____
Are there sensitivities to texture? Explain. _____
_____

Are there sensitivities to temperature? Explain. _____
_____

Are there concerns with your child's ability to bite, chew, move food around in the mouth, or swallowing? Explain. _____
_____
_____

Please describe your child's sleep habits (include bedtime routine, # of hours, # of naps, if any).
_____
_____
_____

Please describe how your child typically gets dressed. (Include how much assistance is needed, length of time, preference for certain fabrics/avoidance of textures). _____
_____

Can your child fasten snaps? _____buttons? _____zippers? _____

Buckles? _____ Velcro enclosures? _____Tie shoes? _____

Please describe bath time for your child (level of independence, like/dislike, preference for a bath or shower) _____
_____

Please describe your child's ability/tolerance of:

Brushing teeth _____
Brushing hair _____
Washing hands/face _____

Is your child toilet trained? _____ If so, when did this occur? _____

Please describe if there were/are any problems with toileting. _____
_____

Please describe your child's ability to keep track of personal belongings. _____
_____
_____

Please describe your child's ability to independently organize his/her bedroom, backpack, desk.
_____
_____

*** MOTOR SKILLS ***

Please describe your child's fine motor and visual motor skills (manipulation of small objects and toys/ dexterity, grasp on pencils/crayons, control/accuracy, quality of writing). **Please do not leave this area blank**
_____
_____
_____

Please describe your child's gross motor skills (balance, coordination, jump/hop/ gallop/skip, endurance, strength). **Please do not leave this area blank**
_____
_____
_____

Can your child ride a bicycle (tricycle or two wheeler)? Please describe.
_____
_____

Please describe how your child ascends and descends stairs (alternates feet, holds rail, etc.).
_____

Please describe your child's performance on jungle gym type equipment (preferences, tolerance for swings, climbing, level of independence). _____
_____
_____

Describe your child's play skills. Include his/her interests, favorite toys/games, pretend themes used in play, etc. _____
_____
_____

Does he/she use toys the same way each time play occurs or is his/her play constantly changing and evolving? Please describe. _____
_____

What do you feel are your child's strengths? _____
_____
_____
_____

What are your main concerns? _____
_____
_____
_____

Who referred your child for OT services? _____

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I. CONSENT FOR SERVICES

I give permission for Skills on the Hill, LLC to provide evaluation, treatment, and/or consultative services to _____. _____ _____

Child **Parent/Guardian Signature** **Date**

II. CONFIDENTIALITY POLICY

At Skills on the Hill, we are committed to maintaining client confidentiality. However, due to space constraints, we are unable to meet with each of our clients in a private room at the end of each session. Therefore, we use the waiting room to provide you with information about your child's therapy session and home recommendations. We understand that you may prefer an alternative arrangement. If so, please let us know and we will accommodate you. If you prefer, you can schedule a meeting or phone consult with your child's therapist every 1-2 months in place of one of your child's sessions or in addition to his/her session.

_____ _____ _____

Child **Parent/Guardian Signature** **Date**

_____ I DO GIVE permission for my child's therapist at Skills on the Hill to discuss and share verbal and/or written information about my child in the public waiting room at the end of each session.

_____ I DO NOT GIVE permission for my child's therapist at Skills on the Hill to discuss and share verbal and/or written information about my child in the public waiting room at the end of each session. I will schedule a meeting or phone consult with my child's therapist every 1-2 months to discuss my child's therapy sessions. I understand that I will be billed for this meeting and that I may schedule this meeting in lieu of one of my child's therapy sessions.

_____ _____

Parent/Guardian Signature **Date**

III. PERMISSION TO PHOTOGRAPH

I hereby give my permission to Skills on the Hill, LLC, and their staff to photograph or videotape my child. I understand that photos/videos will be used for educational/promotional purposes. I specifically waive any rights to compensation with respect to my child's name, likeness, picture and/or voice.

yes/no *educational purposes* yes/no *promotional purposes* _____

Parent/Guardian Signature

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IV. AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____(parent/guardian) , give my permission to Skills on the Hill, LLC to exchange information (either in writing or orally) about _____(child), whose date of birth is_____, with your insurance provider(s), physicians, programs, teachers, or other persons. (*Please include contact information for ALL professionals working with the child*):

_____ _____
_____ _____

This will release Skills on the Hill, LLC from all legal liability that may arise as a result of their compliance with my request.

_____ _____
Parent/Guardian signature **Date**

V. CANCELLATION & ATTENDENCE POLICY

As you and your child have made the commitment to therapy, we have made the same commitment to you in reserving your scheduled weekly time slot(s). Excessive absences affect your child's rate of progress and take away valuable therapy time another child may need who is on our waiting list.

We expect clients to consistently attend scheduled therapy sessions. Please give us as much advance notice as possible if you need to cancel an appointment. This includes changes in schedules due to school fieldtrips, vacation plans, and medical appointments. **A cancellation made less than 24 hours before a session or a missed appointment (NO SHOW) will be charged $75.00. All canceled sessions are expected to be rescheduled or made up.** When a session is rescheduled, the cancellation fee will be waived.

Of course exceptions to this policy will be made in the event of an emergency or illness. ***Please do not bring a sick child to therapy. A child must be free of fever, pink eye, lice, or diarrhea for 24 hours before resuming OT sessions*.** He/she will not be able to perform at his/her full potential.

No charge will be applied for a therapist cancellation. We will make every effort to make up such sessions.

If there is a Federal Holiday (usually occurring on a Monday) or school is cancelled because of weather conditions, assume that Skills on the Hill will be open unless you are contacted by your child's therapist to cancel or reschedule treatment. Skills on the Hill is a medical practice and we do not follow the typical *school* calendar.

_____ _____
Parent/Guardian signature **Date**

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VI. PAYMENT POLICY AND INSURANCE

In an effort to help families with insurance reimbursement for therapy expenses, Skills on the Hill will obtain authorizations for therapy services (when required) and submit claims electronically to your insurance carrier on your behalf. **This does not mean we have a contract with every insurance, as we are still out of network with most insurance.** However, your claims submission will be timely and our billing department will follow-up on any unpaid claims issues. After insurance reimbursement, you will never be out-of-pocket more than our current self-pay rate for services (please see attached Fee Schedule)

Using the Verification of Benefits form, our billing office will verify your insurance benefits and talk to you about them via phone. Our billing staff is experienced with therapy services and they will be able to answer all of your questions related to benefits, claims processing, as well as your billing statements. Please be available to them so that you can have all of your questions answered.

You **will not** be billed until your claim has been processed by your insurance. You will receive a statement from us every 28 days **if** you have a balance due. You will then have (5) days to review the statement and call the billing department with any questions/concerns about the charges. Unless there are corrections, your credit card will be charged for the full amount shown on your statement.

For our **BCBS families**: In most cases, **the payment for services will be sent directly to you**. Please be looking for your payment and deposit the check directly into your bank account. The billing office will verify with the insurance company the specific amount of the reimbursement paid to you, then they will send you a statement to reflect payments and charge your credit card.

I understand that occupational therapy services must be medically necessary in order for insurance to consider coverage and that information in my benefits manual does not guarantee coverage. I also understand that service may or may not be covered by my health plan. I agree to pay the current patient responsibility rate for any occupational therapy services that are non-covered.

_____

Parent/Guardian signature **Date**

It is our pleasure to provide high quality pediatric OT services to your child(ren). We know that submitting the claims to your insurance for you relieves you of having to work on your own for insurance reimbursement. *For questions, please contact our Billing Office:* ***202-424-2718*** *or* ***skills@hspmd.com.*** Our regular therapy staff will not be able to answer your questions or discuss your insurance claims or your statements as they are not involved with the insurance processing.

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I give permission to Skills on the Hill, LLC to use my credit card information below in order to process payments for occupational therapy services for my child. I understand a credit card must be on file for all patients.

_____
Patient

_____ _____
Parent/Guardian **Date**

Type of Credit Card: (Please circle or mark) VISA MASTERCARD AMEX DISCOVER

Name as it appears on card: _____

Card Number: _____

Security Code: _____
(3-digits or 4-digits for Amex)
Expiration Date: _____

Address associated with credit card: _____

_____

Phone number associated with card: _____

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*** SELF-PAY FEE SCHEDULE ***

(Effective 1/1/2019)

Occupational Therapy Full Evaluation (ages 3 and up) $700.00
(Includes comprehensive administration, scoring, written analysis, and 1-hour parent meeting)

Occupational Therapy Short Evaluation ……..……$500.00
(includes shortened administration, scoring, condensed summary report, 1-hour parent meeting)

Occupational Therapy Infant/Toddler Evaluation (up to age 2) ……..……..……. $530.00
(Administration, scoring, written report, and 1-hour parent meeting– up to 2 years of age)

Occupational Therapy Torticollis Evaluation (infant)……..……..… $290.00
(Includes evaluation, instruction in home exercise program/positioning, and report)

Sensory Integration & Praxis Test..... $900.00
(Administration, scoring, written report, and 1-hour parent meeting. This is a very specific test and examiner will decide if child is appropriate candidate)

Occupational Therapy Feeding Evaluation ……..…… $680.00
(Administration, scoring, written report, and 1-hour parent meeting)

Occupational Therapy Clinic Session..... $150.00/hour

Feeding Therapy Session ……..……..……..……$165.00/hour

Off Site Therapy Session (school, day care, home) $158.00/hour

Occupational Therapy Consultation……..... $150.00/hour
(self-pay rate and includes phone consults/meetings with parent/professionals over 15 minutes)

Occupational Therapy Group……..……..... $93.00/hour

Missed Appointment/Late Cancellation…….……..... $80.00

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Provide treatment and services
- Bill and collect payment from you, your insurance company, or a third party payer
- Conduct healthcare operations such as assess my care and outcomes as well as quality assessments

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of my rights and the uses and disclosures of my health information. I understand that Skills on the Hill has the right to change its *Notice of Privacy Practices* and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that Skills on the Hill restricts how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that this organization is not required to agree to my requested restrictions, but if the organization does agree then it is bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

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*********************************PLEASE KEEP A COPY FOR YOUR OWN RECORDS*********************************

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. If you have any questions about this notice, please the contact Facility Privacy Official Kristen Masci at (202) 544-5439.

Our Responsibilities
We are required by law to maintain the privacy of your health information and provide you with a description of our privacy practices. We will abide by the terms of this notice.

Uses and Disclosures
The following categories describe how we may use and disclose your medical information.

For Treatment: We may use health information about you to provide you treatment or services. This means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

For Payment: We may use and disclose health information about your treatment and services for such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

For Health Care Operations: Members of our staff may use information in your health record for the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review. We may disclose information to students for educational purposes. We may remove information that identifies you from this set of health information to protect your privacy. We may contact you to remind you that you have an appointment; assess your satisfaction with our services; tell you about possible treatment alternatives; tell you about health-related benefits or services; and we may leave messages on your answering machine or voice mail regarding primary appointment reminders and billing/ collections efforts.

Future Communications: We may contact you in the future via newsletters, mail outs, or other means regarding treatment options, health related information, or other community based initiatives or activities our facility is participating in.

Organized Health Care Arrangement: This facility and its staff members have organized and are presenting you this document as a joint notice. Information will be shared as necessary to carry out treatment, payment, and healthcare operations. Therapists and caregivers may have access to protected health information in their offices to assist in reviewing past treatment as it may affect treatment at the time.

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Any other uses and disclosures will be made only with your

written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the right to:

Inspect and Copy: You have the right to inspect and obtain a copy of your health information, including billing records.

Amend: If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our facility. Any request for an amendment must be sent in writing to the Facility Privacy Official.

An Accounting of Disclosures: You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment, or healthcare operations where an authorization was not required.

Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care (i.e., family member or friend). Any request for a restriction must be sent in writing to the Facility Privacy Official. We are required to agree to your request only if 1) except as otherwise required by law, the disclosure is to your health plan and the purpose related to payment of health care operations (and not treatment purposes), and 2) your information pertains solely to health care services for which you have paid in full. For other requests, we are not required to agree. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Request Confidential Communications: You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we contact you at work instead of at home or in a private room, rather than in the waiting room. The facility will grant requests for confidential communication at alternative locations and/or alternative means if the request is submitted in writing and the written request include a mailing address where the individual will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

A Paper Copy of this Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Changes To This Notice

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the facility and on our website and include the effective date.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with this facility. You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

Other Uses of Health Information

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us with permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you and documented in our facility.