For office use Active Insurance ☐	*Previous evaluation* ☐	*Hearing exam* ☐	*Prescription* ☐	*IFSP/IEP/504* ☐

Diverse Therapy, Inc.

Permission for Evaluation and Treatment

I, _____ (parent/guardian) give Diverse Therapy, Inc permission to evaluate and treat _____ (child's name).

I know that all records will remain confidential and will not be released without my permission and signed consent. I understand that I have the right to review all records pertaining to his/her care at my request.

_____ _____

Parent/Guardian Signature Date

Explanation of Services and Fees for Services

Once you have signed the **Permission for Evaluation and Treatment**, an assessment will be conducted for Occupational Therapy / Speech Therapy services (***circle one***). Your child's skills will be assessed using a norm-referenced standardized measure (s), clinical observation and parent/caregiver report. Upon completion of the testing, you will be notified of recommendations for your child to receive Occupational Therapy / Speech Therapy (***circle one***) through an evaluation report. You may be called or asked to complete information forms from the clinician to obtain any previous medical history that will be included in the report.

Services will only be delivered if there is a delay in sensory processing/gross/fine motor skills or expressive/receptive speech skills. If there are other developmental or medical concerns present, you will be informed and recommendations made for further assistance.

Fees for services will be billed to the appropriate insurance carrier or the family (private payment). If Diverse Therapy, Inc. is not a provider of the child's insurance carrier, the agency will accept private payment or refer the child to local agencies that accept his/her insurance. You (parent/guardian) are responsible for payment if any fees are not covered by the appropriate insurance carrier.

Please check one of the following:

☐ My child has _____ (insurance type) and I give Diverse Therapy, Inc. permission to bill child's payment source for assessment and treatment.

☐ My child does not have insurance and I would like recommendations and assistance with obtaining services for my child.

☐ I do not want my child to be evaluated at this time.

Parent/Guardian Signature _____

Diverse Therapy, Inc.

INFORMATION FORM

Date: _____ Appointment time: _____

Family Information

Child's Name: _____ Date of Birth: _____
Mother's Name: _____ Cell Phone #: _____
Email: _____ Home/Work phone#: _____
Address: _____
_____

Father's Name: _____ Cell Phone #: _____
Email: _____ Home/Work phone#: _____
Address: _____
_____

Child lives with:
☐Birth Parents ☐One Parent ☐ Parent & Step-parent ☐ Adoptive Parents ☐Foster Parents

Siblings: Name, age, gender, grade, medical concerns (Y/N):

_____
_____
_____

Is there a language other than English spoken in the home? ☐Yes- *what Language?* _____ ☐No

Babies Can't Wait

Babies Can't Wait parents please provide the child's mot current IFSP

BCW Coordinator: _____BCW Coordinator phone number: _____

Insurance

Insurance company: _____
Insurance id #: _____
Pediatrician Name: _____
Office Name: _____
Office Phone#: _____
Office Fax #: _____

Diverse Therapy, Inc.

Family Concerns

Areas of concern	Specific concern	What you would like your child to do
Self-care (dressing, eating, toileting, bathing)		
Academic (reading, writing, etc.)		
Motor (play skills, gross/fine motor)		
Social skills		
Communication (speaking, understanding, easy to understand)		

Additional information:

_____

_____

_____

Birth History

☐ Full Term Pregnancy ☐ Uncomplicated Pregnancy

☐ NSVD (normal spontaneous vaginal delivery) ☐ Caesarean Section

Gestational Weeks: _____ Birth Weight: ____lbs ___oz

List any complications during pregnancy/delivery: _____

_____

List medications during pregnancy: _____

_____

How long was your baby in the NICU _____ days/weeks/months?

How long did you baby receive oxygen _____ days/weeks/months? _____ Liters

Check all that apply: ☐IVH ☐Transfusions ☐ Feeding Tube

Current Diagnosis: _____

Current Medications: _____

Surgeries: _____

Neurological Test/Results: _____

Other Complications: _____

Diverse Therapy, Inc.

Developmental History

Developmental milestones:

Rolling Age: ____
Sitting Age: ____
Crawling Age: ____
Walking Age: ____

Toilet trained Age: ____

Cooing: Age: ____
First word Age: ____
Put words together: Age _____

Is your child a picky eater? ☐ Yes ☐ No (beef, turkey, chicken, pork, grains, vegetables, fruits)
Typical foods eaten: Breakfast: _____
Lunch: _____
Dinner: _____

Allergies? _____

Therapy History

Current/previous therapies received:

☐ Occupational Therapy ☐ Speech & Language Therapy ☐ Physical Therapy ☐ Behavioral Therapy
Name of Therapy office: _____
Dates attended: _____
Other services received: _____

Other Medical Services Providers

Is your child seen by any of the following doctors?
☐ Cardiologist ☐ Neurologist ☐ Gastroenterologist ☐ ENT ☐ Orthopedist ☐ Psychologist ☐ Psychiatrist:

School Information

Name of school: _____
County: _____
Grade: _____
Type of classroom: General education Special Education Inclusion Other _____
Does your child have an IFSP _____ IEP _____ 504 Plan _____

PROVIDE OFFICE WITH A COPY OF THE IFSP/IEP

Thank you.