OT for Spirited Kids & Adults
LifeSkills, LLC

Physical Address: 505 W Northern Lights Suite 102 Anchorage, AK 99503
Mailing Address: 200 W 34th #427 Anchorage, AK 99503
Phone # 907-205-4366 Cell# 907-538-5951 Fax # 1-877-409-9161
otforspiritedkids@gmail.com www.otforspiritedkids.com

Client's Last Name: ___________________________ First Name: _________________ Nickname: ____________

Sex: ___ Client's Pronouns:_____ Client's DOB ___/___/_____ Address: _______________________________

City: ___________________________, Alaska Zip: ________ Cell/Text: _________________________________

Parent or Guardian's Name (s): ____

Email Address: ______________________________________ Emergency Contact: _________________________

Primary insurance name: ______________________________ Policy ID# ____________________ Group# __________

Guarantor: ____ Guarantor's DOB: ____/____/______

Secondary insurance name: ___________________________ Policy ID#____________________ Group# ___________

Guarantor: ____ Guarantor's DOB: ____/____/______

Initial the lines below to grant OT for Spirited Kids & Adults, Lifeskills LLC the following permissions.

_________ I give consent for the examination and the performance of any tests or therapeutic intervention needed.

_________ I give Lifeskills LLC permission to submit billing directly to the insurance company.

_________ I am financially responsible to the services provided, co-pays, deductibles and other.

_________ I will notify Lifeskills immediately if there is a change in policy or insurance.

_________ I consent for Lifeskills LLC to contact EMS, APD in the event of an emergency.

_________ Acknowledgment of receipt of notice of privacy practices (HIPAA)

_________ I give permission for photo & video to be taken of Client for the purposes of treatment, education, & documentation.

_________ I give permission for photo & video of Client for the purposes of advertising, through brochure and website.

_________ Transportation: I give permission for my child to be transported by OT for Spirited Kids & Adults, Lifeskills LLC to and from activities such as, but not limited to, the playground, the store, and off-site field trips.

_________ Cancelation Policy: Please give our office 24-to-48-hour advance notice if you are unable to make an appointment.
3 consecutive cancelations may result in losing your current OT time slot.
3 canceled appointments with less than a 24-hour notice will be marked as 1 no call, no show.

_________ No Call, No Show Policy: If you have 3 appointments that are no call, no show within 2 months, your time slot will be given to another patient. Your name will then be added to the waitlist for rescheduling.

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Referring Physician:____ Phone:________________________________

Custody arrangement: (circle one) **Full** **Shared** **DPOA** **OCS**

Present living situation: (circle one) **Bio** **Adopt** **Foster** **Other**

Describe present living situation: ____

____

MEDICAL HISTORY: surgeries, hospitalization, previous therapies, school district testing (IEP, BIP), major injuries, major emotional trauma events, prematurity, violence exposure

1.____

2.____

3.____

4.____

Medications:	Food Allergies/ Sensitivities
1.____	1. ____
2.____	2. ____
3.____	3. ____

Has client had vision tested? **Yes** **No**
Has client had hearing tested? **Yes** **No**

Please list any specific issues that you would like to see addressed in OT.

1.________________________________ 2. ________________________________ 3. _______________________________

Circle any areas of concern:

sensory behavior gross motor fine motor coordination playing endurance

learning executive functioning self-care chores making friends toileting communication

Has client had intervention elsewhere? ___________ Has client had a neuro-psychological evaluation? ___________

Describe the client's personality: ____

____

____

Activity	Completes independently?		Add'l Notes - sensitive, minimal help, or refuses
Bathing	Yes	No	
Dressing	Yes	No	
Toileting	Yes	No	**Wipe adequately?** Yes No
Brushing Teeth	Yes	No	**Brush completely?** Yes No
Brushing Hair	Yes	No	
Utilizing spoon, knife & fork	Yes	No	
Manages & organizes backpack for school	Yes	No	
Manages belongings	Yes	No	
Wakes up dry	Yes	No	

Has client had a sleepover at a FRIEND'S house (not including family)? **Yes** **No**

Describe that sleepover and client's behavior: ____

____

How often does client cry or fuss ______________ per week and why ____
How often does client get aggressive ___________ per week and why ____

Describe client's relationship with family: **Aggressive** **Cooperative** **Able to negotiate** **Avoids**

____

____

Describe client's relationship with peers: **Aggressive** **Cooperative** **Able to negotiate** **Avoids**

____

____

List three chores that client is responsible for/can complete independently: Receives Allowance? **Yes** **No**

1.______________________________ 2. _________________________________ 3. ________________________________

Does client participate in any sports? **Yes** **No**
Is client clumsy? **Yes** **No**
Is client a picky eater? **Yes** **No** (avoids certain foods)
Does client avoid certain clothing textures? **Yes** **No** (hats, tags, socks, long sleeves, etc.)
Is client sensitive to noises? **Yes** **No** (too loud, covers ears, runs away, etc.)
Does client get sick often? **Yes** **No**
Does client make friends easily? **Yes** **No**
Does client take turns during conversation? **Yes** **No**
How many hours of electronics do they have access to daily? ____

____ __________________________________

Patient/Parent or Guardian Signature **Date**

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MEDICAL RECORDS RELEASE: Please complete the following if you would like another person or Faciltiy, other than primary physician, to receive a report.

Patient Name: ______________________________________ **Date of Birth**: ____________________________

Take notice that I or the legally authorized representative, authorize Lifeskills LLC to release medical and health records via verbal exchange and/or paper copy that will be shared with the person or facility listed below.

Please note: Primary physician and insurance company are automatically released as needed.

Release Medical & Health Records via Verbal Exchange and/or Paper Copy with the Following:

Name of Person or Facility:	**Relationship to Patient (E.g. Parent, School, SLP):**
Address:	
Phone Number:	**Fax Number:**

This Authorization expires on the patient's discharge from OT for Spirited Kids & Adults, Lifeskills LLC.

____ _________________________
Signature of Parent, Legal Guardian, or Patient **Date**

____ ____
Printed Name **Relationship to Patient**

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Attendance Policy

Cancelation Policy

If you are unable to make it to your scheduled appointment, **please give our office 24-to-48-hour advance notice.** Unforeseen events or illnesses do arise, but, if possible, this courtesy call allows us time to schedule other patients who are on a waiting list.

- 3 consecutive cancelations may result in your child losing their current OT time slot.
- 3 canceled appointments with less than a 24-hour notice will be marked as 1 no call, no show.

No call, No Show Policy

- 3 appointments that are no call, no show within 2 months, your time slot will be given to another patient.
- Your name will be added to the waitlist for rescheduling.

Late Policy

If you are running late, please let us know by text or call. If being late is a continuous problem, we will reach out to see if your time is appropriate for your family and what needs adjusted to make your entire session time.

Patient name____ Date___________________________

Patient/Parent or Guardian Signature____

Please call or text the office cell phone – 907-538-5951 – anytime of the day or night to let us know about cancelations.

Your appointment time is scheduled especially for you!
Please respect our time and yours by keeping us informed by phone, text, or email.
Please call if you have any questions or concerns.

Thank you for choosing us to work with your family! ~ OT for Spirited Kids and Adults

Call: 907-205-4266 **Text**: 907-538-5951 **Email**: otforspiritedkids@gmail.com