FUNCTION JUNCTION

Pediatric Occupational Therapy

Client & Billing Intake Profile

Client Details

Name:	Gender: M F
Date of Birth (D/M/Y):	School:
School Year:	Teacher:
Diagnosis (if any) Date diagnosed:	Doctor's Name:
Medications/Medical Precautions (if any)	Client Mailing Address:

Billing & Insurance Details

***Please scan and attach insurance card**

Insurance Co:	Policy type:
Insured Parent Info: Name: Date of Birth: Place of Employment:	Certificate No. Policy/Group No.

Preferred email for Billing:
Preferred email for Therapy Contact:

Parents/Caregiver Contact Details

Name	Contact info. (email & phone)
Mother:	
Father:	
Caregiver:	

Admin use only:
Diagnosis code:_____

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Client:	Date of Birth (D/M/Y):

Authorization to Release Information and Pay Insurance Benefits

I hereby authorize Function Junction to provide therapy services to my child and to release any information regarding diagnosis and treatment of my child to my Insurance Co. regarding my claim. Also, by my signature, I authorize payment directly to Function Junction. I understand that I am responsible for any amount not covered by my Insurance Company.

_____
Signature of Parent/Guardian

Parent/Guardian's Name: _____ Date:_____

Confidentiality & Release of Information

Function Junction recognizes that Bermuda is a small community. Confidentiality and maintaining your trust are important to us. However, progress takes a team effort. Function Junction is sensitive when discussing individual's medical history or therapy plans with other service providers. Be aware that some evaluations and sessions will be video recorded and occasional photos will be taken to document progress. **All written reports will be provided to parents before they are shared with external providers.**

	Name of organization/individual
School	
Doctor/Pediatrician/ Optometrist…	
Other Service Providers (OT/PT/SLP Psychology/ Reading Clinic…)	
Other	

☐ I authorize Function Junction to contact and share information with the individuals I have indicated above, for the purposes of my child's therapy evaluation and treatment plan.

_____
Signature of Parent/Guardian

Parent/Guardian's Name: _____ Date:_____

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Tell us about your child

Child's Name:	Date of Birth:

What does your child like to do? *At home:* *Outside:* *On a Rainy day:* *Special interests*: *Favourite toy/game:*	List current extracurricular activities (include days/times): List some of their past extracurricular activities:
Medical History (diagnosis, birth hx., major illnesses, further testing…) Medical Precautions (eg. Asthma, allergies, ..) Current medications	Vision Tested recently? Yes No Hearing Tested recently? Yes No Other Services (current or past)? Learning Support Yes No Speech Therapy Yes No Physio Therapy Yes No Psychology Yes No Other Yes No

What is your main concern? (What has brought you to OT? Is there a question you would like this evaluation to address?)
Is there anything you would like us to know about your child prior to the evaluation?
How did you hear about Function Junction?