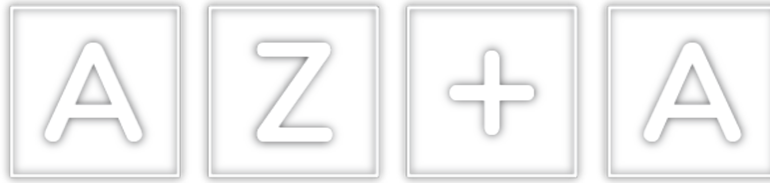


Amy Zier & Associates, Inc.

2319 N. Orchard Street
Chicago, IL 60614

www.amyzier.com

Phone: 773.755.7793

Fax: 773.755.7792

Welcome!

Amy Zier & Associates, Inc. offers comprehensive evaluations. Standardized and alternative testing methods are used in order to best learn about your child's individual profile.

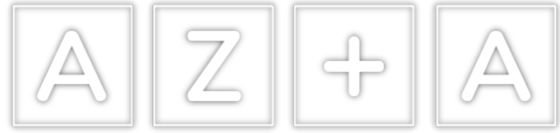
Please complete the enclosed forms, along with the Sensory Profile and Motor Questionnaire, in order to assist with the evaluation/screening process.

Print clearly so that all information is legible. Do not write in cursive.

If possible, return forms (via fax, mail, or email) prior to the first evaluation date. Otherwise, bring them with you to the first scheduled session.

Remember to check that you have filled out all the forms completely, including your child's name at the top and your signature on the bottom of each page.

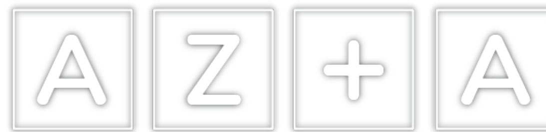
We look forward to meeting you.



Child's Name: ____

1. **Cancellation Policy**: 24-hour notice is required for cancellations or you will be charged for services (i.e. groups, individual, intensive, parent/guardian meetings, and school meetings). Call in, even if you are not yet certain you will have to cancel, to avoid being charged for services. This charge is not eligible for insurance submission.
2. **Sick Policy**: In order to maintain the health of the staff and other children, do not bring your child if they have had a fever or experienced symptoms that may be contagious within a 24-hour period. If you find your child has lice or another contagious illness after attending the clinic, please notify us as soon as possible to allow us to implement precautionary measures as quickly as possible.
3. **Parent Meetings**: It is typical for therapists to have parent meetings per month outside of standard session time. Parent meetings are a critical component of AZ+A's comprehensive approach to therapy as they play a large role to ensure understanding of the work and process.
4. **School Observations and Sessions**: It is common that therapists visit a child's school, occasionally or frequently, to observe or integrate with the classroom and collaborate with the school team to support child's progress.
5. **Consultation Policy**: Consultations are charged at the rate of an individual session. Clinical time will be billed for therapist collaboration with professionals on the child's team. This includes phone calls or meetings with:
   - Teachers
   - Physical therapists
   - Speech therapists
   - Psychologists
   - Pediatricians
   - Attorneys
   - Government professionals
   - Etc.

   If a report is requested such as progress summary, school application support, or other requests, cost is maximum one additional clinical hour.
6. **Documentation/Written Evaluation, Re-Evaluation, and School Reports**: Reports are not included as part of standard clinical cost of session. If you would like to opt out of obtaining a written clinical report, please let your OT know at start of evaluation, re-evaluation, or school observation sessions. Cost for written reports is maximum one

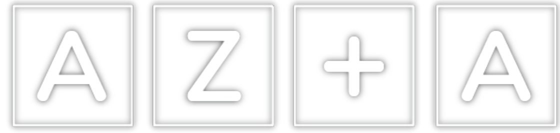


clinical hour each evaluation/school observation. Cost ranges from $135-190 depending on therapist's clinical rate.

7. **Late Pick-Up:** In order to respect the appointments after your child's session, please pick up your child on time. You will be charged $15.00 for every 5 minutes you are late for pick up. This charge is not eligible for insurance submission.
8. **Late Drop-Off:** In order to respect the therapist's time, please drop your child off on time. Charges will begin at the regular rate from the start time of your child's scheduled appointment, not from the time your child arrived, and continue until the end of the session.
9. **Clinical Supervision:** Occupational Therapists receive regular clinical supervision. Clinical supervisors are held to the same confidentiality requirements as your therapist.
10. **Allergen Alert:** Please note that our clinic is soy and nut free. Do not bring snacks with you into the clinic that contain either of these ingredients; some of the children are extremely allergic. If your child has any special dietary needs, notify us in the Food Permission/Dietary Information section of this packet.
11. A prescription from your pediatrician for occupational therapy is necessary for us to evaluate and treat. Please have your doctor email it to our office at **operations@amyzier.com** prior to your first evaluation session. It should read "OT evaluate and treat" and we commonly use the diagnosis code R27.8, Dyspraxia, as a starting point. You can call and request the prescription from the pediatrician over the phone and often without a physical appointment. If you need assistance, let us know.
12. **AZ+A Email List:** As a patient of AZ+A we automatically add all new families to our email list. Should you wish, you may unsubscribe at any time.
13. **Physician Reports:** By default, we send completed reports to referring physicians. If you do NOT want report to go to MD, check the box below.

I do NOT want a report to go to my referring Physician.

Signature ____Date____________________



PATIENT DATA

Please print information clearly.

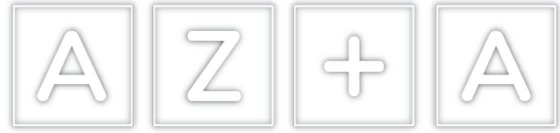
Date: ______________________

Child's Full Name:	
Child's Date of Birth:	
Parent/Guardian Name(s):	
Address:	
City, State, Zip Code:	
Home Phone:	
Work Phone:	
Cell Phone:	
Email Address:	
Sibling Names & Ages:	
Emergency Contact:	
Emergency Phone:	
Relationship to Child:	

How did you hear about AZ+A?

What is your primary concern for having your child evaluated?

Has your child been evaluated before?



If yes, provide date/location and diagnosis if one was given.

Has your child ever received therapy services in the past? ________________________________

If yes, provide location, therapists' name, type of therapy and important related information.

Is your child currently receiving any other therapy or in a treatment program? _______________

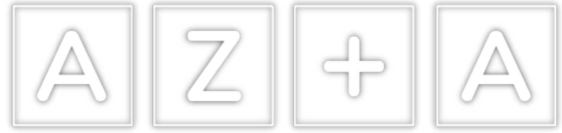
If yes, what type and intensity? List names and phone numbers to assist with team collaboration.

Primary Care Physician Information	
Physician Name:	
Phone Number:	
Fax Number:	
Address:	
City, State, Zip Code:	

Is your child currently being treated by any doctors?

____

If yes, list name(s), address(es), and phone number(s).



Has your child had an EEG? When and what were the results?

Is your child currently on any medication? ____

If yes, indicate what type of medication and how long the child has been taking it.

Does your family have a history of mental illness (ex. depression, bipolar disorder)?

Does your family have a history of learning disabilities?

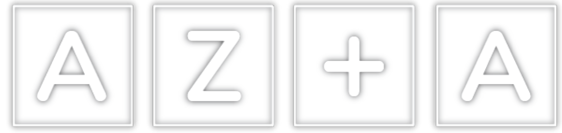
Is your child on a special diet? ____

Does your child have any food allergies? ____

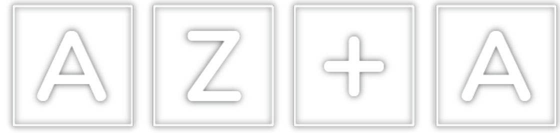
Has your child seen a Nutritionist? ____

Is your child enrolled in a school program? ____

If yes, provide name of school district, teacher's name/phone number and therapists' names/phone numbers.



Is there anything else we should know about your child?



FOOD PERMISSION + DIETARY

Child's Name: ____

Complete the following to inform AZ+A staff of your child's diet restrictions and your preferences for participation in snack time. Many of our group sessions include a snack time. Families are encouraged to bring a snack each week. **Please keep in mind that our clinic is nut and soy free.** Please observe our restrictions when planning your child's snacks, both in the waiting room and in sessions.

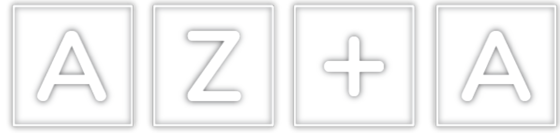
My child may participate in snack time and I will provide his/her snack.

My child should not participate in snack time. If there is a specific reason, please list:

My child has the following food allergies/sensitivities:

List food(s) your child is motivated to eat:

Signature ____ Date ___________________



PHOTOGRAPH + VIDEO RELEASE

Child's Name: ____

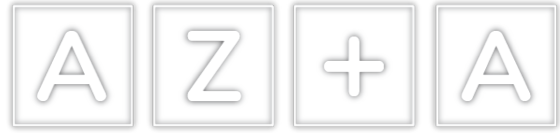
It is a common policy that AZ+A therapists use video for evaluation and treatment sessions to have visual record of the child's needs and to note progress.

I give permission for my child's picture/video to be used by AZ+A for marketing/publicity.

I give permission for my child's picture/video to be used by AZ+A for the purpose of training other professionals and paraprofessionals and learning through supervision.

I do not wish my child's picture/video to be used for any purpose other than training his/her specific clinical team and learning from supervisors.

Signature ____ Date ____________________



CONSENT FOR RELEASE OF INFORMATION

Child's Name: ____

I authorize AZ+A to provide those below with any information requested regarding the occupational therapy services for my child. **AZ+A cannot submit claims to your insurance provider without signature of this release.**

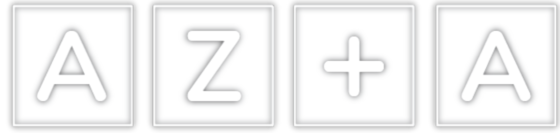
This information includes, but is not limited to, the demographic data, written records, financial records, and billing records of above patient. Include the name, title, and phone number for each person/institution listed.

Collaboration with other professionals is a priority to creating a comprehensive program supporting success. Please remember to include all necessary parties including pediatrician/family physician, insurance company, speech or physical therapist, insurance advocate, relatives, lawyers, schools, teachers, etc., any person/institution who may need information about your child's occupational therapy records.

Please print the information clearly.

Contact Name	Title (Physician,etc.)	Phone Number	Email

Signature ____ Date ____________________



Child's Name: ____

Illinois State Law mandates that we have a written prescription from your child's doctor prior to starting treatment. These must be updated every six months and we must have a current prescription in your child's file at all times.

Please obtain a prescription from your child's physician before the start of services. It is common practice that a doctor will write a prescription for OT without a clinic visit. Call the doctor's office and speak to a nurse regarding the prescription request. The prescription needs to say: "Occupational Therapy evaluate and treat."

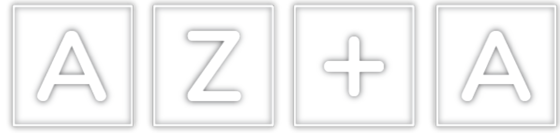
Have the prescription emailed to AZ+A at operations@amyzier.com or give it to your therapist prior to treatment. If you have additional questions, speak to your therapist.

I understand the initial prescription is my responsibility.

Most prescriptions for OT expire after six months. It is AZ+A's practice to contact your pediatrician on your behalf to request an updated script when nearing expiration. This enables us to provide the greatest continuity of care. Please contact the AZ+A office with any objections to this practice

I authorize AZ+A to obtain an updated prescription for my child every six months

Signature ____ Date ____________________



CONSENT FOR TELEHEALTH CONSULTATION

I understand that my health care provider is offering a telehealth/virtual session to me.

1. My health care provider explained to me how the video conferencing technology that will be used to complete a consultation during which the client/health care provider will not be physically in the same room at the time of the consultation.
2. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

CONSENT TO USE TELEHEALTH By signing this document, I acknowledge:

1. Telehealth is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.

2. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment. By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

____

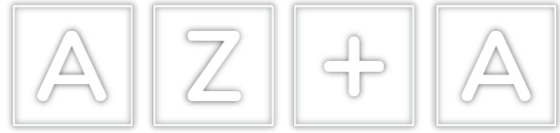
Signature of patient or personal representative

____

Printed name of patient or personal representative and his or her relationship to patient

____

Date



INSURANCE ACKNOWLEDGEMENT

Child's Name: ____

Billing Procedure + Agreement

1. AZ+A submits weekly insurance claims for your child's treatment sessions on your behalf.
2. Insurance will send Explanation of Benefits to you with coverage and payment details.
3. Payment to AZ+A is either due in full at time of service or will be charged to you after insurance processes your claims. If for any reason your insurance doesn't cover your claim, you are fully responsible for payment.

Estimated Fee Schedule

These are estimates only. Your Insurance plan's allowed amount may be above or below the rates listed.

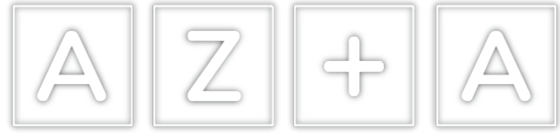
Item Description	Hourly Rate
Evaluations / Screenings	$230/hour
Consultations	*Therapist hourly rate
Treatment	$175/hour
Offsite Visits – e.g. School, Home	$194/hour

Family Insurance Benefits

AZ+A Intake Coordinator will contact you with this information via email.

I understand that charges per visit will depend on my respective insurance plan's allowed amount. Should insurance not fully reimburse, I am responsible for compensating the OT either the difference between the amount reimbursed and allowed amount or the full treatment amount.

Signature ____ Date ____________________



OFFSITE FEE AGREEMENT

Child's Name: ____

When a child is treated offsite, the additional travel time and expenditure is billed to the family.

Fee Schedule

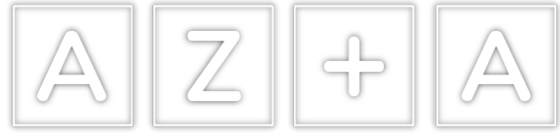
Insurance does not cover this additional fee. You will be responsible for immediate payment.

Item Description	Hourly Rate
Travel Time and Expenditure	$140/hour

Duration	Amount Due
15 minutes	$35.00
30 minutes	$70.00
45 minutes	$105.00

I agree to pay the offsite fee at time of treatment. I understand this fee is not covered by my insurance plan.

Signature ____ Date ____________________



CREDIT CARD AUTHORIZATION

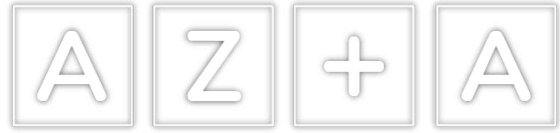
Child's Name: ____

I authorize AZ+A to charge my credit card, debit card, or HSA/Flex Spending card for Occupational Therapy services once a week for the total amount invoiced after it has been processed by Insurance.

Cardholder Information	
Cardholder Name:	
Card Type: **(Visa,MasterCard)**	
Card Number:	
CVC Number:	
Expiration Date:	
Zip Code:	

A photocopy of this form is authorized to serve the same as original.

Signature ____ Date _____________________



INSURANCE INFORMATION

Child's Name: ____

AZ+A submits claims to BCBS once a week and sends invoice documentation via email (to the email address provided in the Patient Data section) after they have processed. Please provide insurance information below for submission to BCBS.

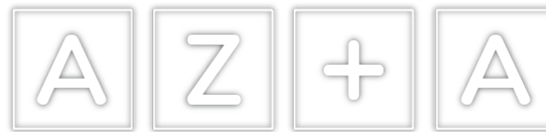
Insurance Information	
Primary Policyholder Name:	
Insurance Carrier:	
ID Number:	
Group Number:	
Customer Service Phone Number:	
Claims Address:	
City, State, Zip Code:	

Provide a copy of both sides of your insurance card.

I have reviewed my insurance policy and understand how I will be billed.

Signature ____ Date ____________________

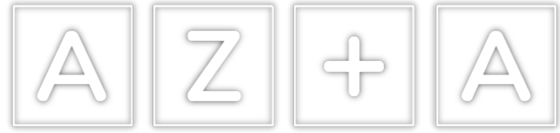
RECEIPT OF PRIVACY POLICY NOTICE



Child's Name: ____

I have received a copy of the "Notice of Privacy Practices" from AZ+A with regard to the treatment of the child named above.

Signature ____ Date ____________________



CHECKLIST

Child's Name: ____

Once you have read through and understand all the material provided in our parent packet, please initial and sign. Return all completed forms, along with this form, to the therapist that is providing your child's evaluation/screening.

I have read, understand and agree to the following:

_____ AZ+A Policies

_____ Patient Data (3 pages)

_____ Food Permission + Dietary Information

_____ Photograph + Video Release

_____ Consent for Release of Information

_____ Request for Therapy Prescription

_____Telehealth Authorization

_____ OT prescription

_____ Insurance Acknowledgement

_____ Offsite Fee Agreement

_____ Credit Card Authorization

_____ Insurance Information

_____ Copy of the front and back of the insurance card

_____ Receipt of Privacy Policy Notice