

# NeuroPlay Central Florida

Pediatric Occupational Therapy

Phone: (352) 729-1796

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Mount Dora, FL | Lake • Orange • Seminole Counties



NEUROPLAY STUDIO  
*Plasticity specialists*

## NEW PATIENT INTAKE & SERVICES AGREEMENT

Please complete all sections and sign where indicated. Return to Carolyn at or before your first visit.

### SECTION 1 OF 7 — PATIENT INFORMATION

#### Child's Information

Child's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Diagnosis/Condition (if known): \_\_\_\_\_ Referring Physician/Provider: \_\_\_\_\_

School/Preschool (if applicable): \_\_\_\_\_ Grade/Teacher: \_\_\_\_\_

#### Parent/Guardian Information

Parent/Guardian #1 Name: \_\_\_\_\_ Parent/Guardian #2 Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Email: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

#### Insurance / Funding Information

Insurance Company (if applicable): \_\_\_\_\_ Policy/Member ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

##### Step Up for Students Scholarship:

I am using a Step Up for Students scholarship (FES-EO or FES-UA)

Scholarship Student ID #: \_\_\_\_\_ Scholarship Type: \_\_\_\_\_

#### Emergency Contact

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

#### Referral & Primary Concern

How did you hear about us? \_\_\_\_\_ Primary reason for seeking OT: \_\_\_\_\_

Describe your main concerns for your child:  
\_\_\_\_\_  
\_\_\_\_\_

## SECTION 2 OF 7 — DEVELOPMENTAL & MEDICAL HISTORY

### Birth & Early Development

<b>Gestational Age at Birth:</b>	<b>Birth Weight:</b>	<b>Age sat independently:</b>	<b>Age walked independently:</b>
<b>Type of Delivery:</b>	<b>Birth Complications?</b>	<b>Age first words:</b>	<b>Age 2-word phrases:</b>
<b>NICU Stay?</b>	<b>If yes, duration:</b>	<b>Currently breastfed/bottle/cup:</b>	

### Medical History

**Current Diagnoses:**

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**Hospitalizations/Surgeries:**

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**Current Medications & Dosages:**

**Primary Care Physician & Phone:**

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**Significant Medical History:**

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**Known Allergies:**

**Other Specialists:**

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### Previous Therapy Services

Service	Provider/Location	Dates	Reason Ended
Occupational Therapy			
Speech-Language Therapy			
Physical Therapy			
ABA / Behavioral Services			
Other:			

### Areas of Concern (check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Fine motor skills / handwriting        | <input type="checkbox"/> Visual motor integration        |
| <input type="checkbox"/> Sensory processing / sensitivities     | <input type="checkbox"/> Coordination / balance          |
| <input type="checkbox"/> Self-care / dressing / grooming        | <input type="checkbox"/> Emotional regulation / behavior |
| <input type="checkbox"/> Feeding / food texture issues          | <input type="checkbox"/> School readiness / academics    |
| <input type="checkbox"/> Play skills / social participation     | <input type="checkbox"/> Toilet training                 |
| <input type="checkbox"/> Attention / focus / executive function | <input type="checkbox"/> Other: _____                    |

### Additional Notes

**Anything else you'd like us to know about your child?**

## SECTION 3 OF 7 — SERVICES AGREEMENT

### Provider Information

**Provider:** Carolyn Talbot, OTR/L | **License #:** \_\_\_\_\_ | **NPI #:** \_\_\_\_\_ | **Practice:** NeuroPlay Central Florida | **Location:** Mount Dora, FL — In-Home Services, Central Florida

### Scope of Services

NeuroPlay Central Florida provides pediatric occupational therapy using an **episodes of care** model. Services include evaluation, individual therapy (30, 45, or 60-minute sessions), feeding therapy, caregiver training, and home exercise programming. All services are delivered **in-home or in the child's natural environment**.

### Fee Schedule

Service	Duration	Rate
Pediatric OT Evaluation	Approx. 2 hours	\$300.00
Individual OT Session	60 minutes	\$100.00
Individual OT Session	45 minutes	\$75.00
Individual OT Session	30 minutes	\$60.00

Payment is due at the time of service. Accepted methods: cash, check, credit/debit card, Venmo. NeuroPlay Central Florida does not bill insurance directly; a superbill is available upon request.

\_\_\_\_\_ I have read and understand the fee schedule and payment policy.

### Step Up for Students

NeuroPlay Central Florida is a registered **Step Up for Students** direct provider. Scholarship payments are processed through the Step Up portal — families do not pay out of pocket for covered services. A **Session Attendance Log must be signed** at each visit. Cancellation fees cannot be paid with scholarship funds.

\_\_\_\_\_ I understand Step Up billing procedures (initial if applicable).

### Cancellation & No-Show Policy

Please provide **24 hours' notice** for cancellations or rescheduling.

- **Late cancellation** (<24 hrs notice): \$40 fee
- **No-show** (no notice): \$60 fee
- 3+ no-shows or same-day cancellations within 60 days may result in discharge from services
- Cancellation fees cannot be paid with Step Up scholarship funds

\_\_\_\_\_ I have read and understand the cancellation and no-show policy.

### In-Home Session Expectations

By signing this agreement, I agree to: ensure a safe space is available for therapy; have my child present at the scheduled start time; remain accessible during sessions; secure pets unless clinically incorporated; and not have unauthorized third parties present during sessions without prior consent.

## SECTION 4 OF 7 — CONSENT FOR TREATMENT

### Authorization for Services

I, the undersigned parent/legal guardian, hereby authorize **Carolyn Talbot, OTR/L** and NeuroPlay Central Florida to provide occupational therapy evaluation and treatment services to my child. I understand that:

- Occupational therapy is a health service aimed at improving function in daily life activities.
- Services will be delivered in my home or natural environment.
- I will be informed of evaluation findings, treatment goals, and my child's progress.
- I have the right to ask questions, request a second opinion, and withdraw consent at any time.
- I will be asked to participate in sessions and carry out home programs.
- Occupational therapy is not a substitute for medical care; I will continue to seek appropriate medical treatment as needed.

### Caregiver Participation

Family-centered care is central to our model. I agree to actively participate in sessions, implement home exercise program (HEP) activities, communicate changes in my child's health or medications, and collaborate with other providers as needed.

### Photography & Video

- I CONSENT** to photographs or video of my child for clinical documentation and/or educational/marketing materials.
- I DO NOT CONSENT** to photographs or video of my child for any purpose.

## SECTION 5 OF 7 — FINANCIAL POLICY

### Financial Agreement

I understand and agree to the following financial policies:

- Payment is due at the time of service unless a prior arrangement has been made in writing.
- Returned checks will be subject to a \$35 returned check fee.
- Accounts with a balance outstanding for more than 30 days may be referred to collections.
- A superbill for out-of-network insurance reimbursement is available upon request. Reimbursement is not guaranteed.
- I am responsible for verifying my insurance benefits and understanding my out-of-network coverage.

### Good Faith Estimate

#### Notice: Right to a Good Faith Estimate

Under the No Surprises Act, you have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost before you receive services. If you are uninsured or choose not to use your insurance, you are entitled to a written estimate. If you receive a bill that is \$400 or more than your Good Faith Estimate, you have the right to dispute it. A separate Good Faith Estimate is available upon request. For more information, visit [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises).

\_\_\_\_\_ I acknowledge receipt of the Good Faith Estimate notice.

## SECTION 6 OF 7 — HIPAA NOTICE OF PRIVACY PRACTICES

### Your Privacy Rights

NeuroPlay Central Florida is committed to protecting your child's health information. This notice explains how we use and protect Protected Health Information (PHI).

#### How We Use Your Information

- **Treatment:** To provide, coordinate, and manage your child's occupational therapy services.
- **Payment:** For billing and collection activities, including Step Up for Students scholarship documentation.
- **Operations:** For quality assessment, compliance, and administrative functions.
- **Required by Law:** We may disclose PHI when required by federal or state law.

#### Your Rights

- Request a copy of your child's health record
- Request corrections to your child's record
- Request restrictions on how we use or disclose PHI
- Receive an accounting of disclosures made without authorization
- File a complaint if you believe your rights have been violated

#### Disclosures Requiring Your Authorization

We will obtain written authorization before releasing PHI to schools, other providers, or third parties except as permitted by HIPAA (treatment, payment, operations, legal requirements).

#### Contact & Complaints

Questions or complaints: contact Carolyn Talbot at (352) 729-1796 or connect@neuroplaystudio.com. You may also file a complaint with the U.S. Department of Health & Human Services Office for Civil Rights at [www.hhs.gov/ocr](http://www.hhs.gov/ocr).

By signing below, I acknowledge that I have received, read, and understood the NeuroPlay Central Florida Notice of Privacy Practices. I understand my rights regarding Protected Health Information and consent to the uses and disclosures described above.

\_\_\_\_\_ *I acknowledge receipt of the HIPAA Notice of Privacy Practices.*

## AUTHORIZATION TO RELEASE INFORMATION (Optional)

### Release of Records

I authorize NeuroPlay Central Florida to release/request records to/from the following (leave blank if not applicable):

**Provider/Agency Name:** \_\_\_\_\_

**Phone/Fax:** \_\_\_\_\_

**Information to release:** \_\_\_\_\_

**Purpose:** \_\_\_\_\_

This authorization may be revoked in writing at any time. Expiration: one year from date of signature unless otherwise specified.



**BONUS — SESSION ATTENDANCE LOG**

## SESSION ATTENDANCE LOG

Required for Step Up for Students Scholarship Documentation • Parent must sign at each visit

**Child's Name:** \_\_\_\_\_ **Therapist:** \_\_\_\_\_ **Month/Year:** \_\_\_\_\_ **Scholarship ID #:** \_\_\_\_\_

#	Date	Time In	Time Out	Service Type	Duration	Therapist Initials	Parent Signature
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							

**Step Up for Students Instructions:** Parent/guardian must sign at the time of each session to verify attendance. This log must be submitted monthly through the Step Up for Students parent portal. Do not submit this log to NeuroPlay Central Florida — retain for your own records.