NeuroPlay Studio™ LLC
Pediatric Occupational Therapy

Phone: (352) 729-1796
Email: connect@neuroplaystudio.com
Central Florida

NEUROPLAY STUDIO
Pediatric OT

NEW PATIENT INTAKE PACKET

Patient Information

Patient Name: _____ Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____ ZIP: _____

Parent/Guardian Information

Parent/Guardian Name: _____ **Relationship:** _____

Phone (Primary): _____ **Phone (Alt):** _____

Email: _____

Preferred Contact Method:
☐ Phone ☐ Text ☐ Email

Emergency Contact

Name: _____ **Relationship:** _____ **Phone:** _____

Medical Information

Primary Diagnosis: _____

Referring Physician: _____ **Physician Phone:** _____

Allergies: _____

Current Medications: _____

Reason for Referral

Primary concerns:

Payment Method

☐ Private Pay
☐ Step Up for Students Scholarship
If Step Up, Student ID: _____

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CONSENT FOR TREATMENT

I, the undersigned, hereby authorize NeuroPlay Studio™ LLC and its licensed occupational therapists to provide occupational therapy evaluation and treatment services to the patient named in this packet.

I understand that occupational therapy may include, but is not limited to:

- Evaluation and assessment of developmental, sensory, motor, and functional skills
- Therapeutic activities to improve fine motor, gross motor, and visual motor skills
- Sensory integration and sensory processing interventions
- Activities of daily living (ADL) training and feeding therapy
- Handwriting and school-readiness activities
- Parent/caregiver education and home program development

I understand and acknowledge that:

- Therapy outcomes cannot be guaranteed, and progress varies by individual
- I have the right to ask questions about any evaluation or treatment procedures
- I have the right to refuse or discontinue treatment at any time
- My child's participation and cooperation are essential for optimal outcomes

Assumption of Risk

I understand that occupational therapy activities may involve physical movement and sensory experiences. While safety precautions are taken, there is an inherent risk of minor injuries during therapy activities. I agree to notify the therapist immediately of any concerns.

Emergency Medical Authorization

In the event of a medical emergency, I authorize NeuroPlay Studio™ LLC staff to seek emergency medical treatment for my child and to contact the emergency contact listed.

Photography/Video Consent (Optional)

☐ I consent to photographs/videos for treatment documentation and progress monitoring only.
☐ I consent to photographs/videos for educational or marketing purposes (social media, website).

Parent/Guardian Signature _____ Date _____

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FINANCIAL POLICY & CANCELLATION AGREEMENT

Payment Policy

NeuroPlay Studio™ LLC accepts **private pay** and **Step Up for Students Scholarship** funds.

📚 **Step Up for Students:** Payment is processed directly through the Step Up portal. Parents must ensure sufficient funds, approve invoices promptly, and notify us of any scholarship status changes. Any balance not covered is due at time of service.

Service	Fee
Evaluation (assessment, plan of care, consult)	$300
OT Session - 60 min	$100
OT Session - 45 min	$75
OT Session - 30 min	$60

Cancellation & No-Show Policy

- **24-Hour Notice Required** for cancellations/reschedules
- **Late Cancellation (<24 hrs):** 50% of session fee
- **No-Show:** Full session fee
- **3 no-shows in 6 months** may result in discharge
- **Late arrivals:** Session ends at scheduled time; 15+ min late = no-show

Cancellation/no-show fees cannot be paid with Step Up funds.

Insurance

We do not bill insurance. Superbills available upon request for self-reimbursement.

Parent/Guardian Signature _____ Date _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Commitment to Your Privacy

NeuroPlay Studio™ LLC is committed to protecting the privacy of your protected health information (PHI). We are required by law to maintain the privacy of PHI and provide you with this Notice.

How We May Use and Disclose Your Health Information

For Treatment

We may use/disclose PHI to provide, coordinate, or manage healthcare, including consultation with other providers.

For Payment

We may use/disclose PHI to obtain payment for services, including billing and collection.

For Healthcare Operations

We may use/disclose PHI for quality assessment, training, licensing, and accreditation.

Other Permitted Disclosures

- As required by law
- Public health activities
- To report suspected child abuse or neglect
- Health oversight agencies
- Court orders or subpoenas
- Law enforcement as required
- To prevent serious threat to health/safety

Your Rights

- **Access:** Inspect and obtain copies of your PHI
- **Amend:** Request corrections to your PHI
- **Accounting:** Request list of disclosures
- **Restrictions:** Request restrictions on uses
- **Confidential Communications:** Request specific contact methods
- **Complaints:** File with us or HHS without penalty

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HIPAA ACKNOWLEDGMENT

By signing below, I acknowledge that I have received a copy of NeuroPlay Studio™ LLC's Notice of Privacy Practices.

Parent/Guardian Signature _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION

I authorize NeuroPlay Studio™ LLC to **release information to** and/or **obtain information from**:

Name/Organization:

Address: **Phone/Fax:**

Information to be Released:

☐ Evaluation Report ☐ Progress Notes ☐ Plan of Care ☐ Discharge Summary ☐ School Records/IEP ☐ Verbal Consultation

Purpose:

☐ Coordination of Care ☐ School Services ☐ Parent Request ☐ Other: _____

I may revoke this authorization in writing at any time. This authorization expires: _____ (or 1 year if blank).

Parent/Guardian Signature _____ Date _____

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NPI: _____ TIN: _____

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GOOD FAITH ESTIMATE

You have the right to receive a "Good Faith Estimate" explaining how much your care will cost. Under the No Surprises Act, providers must give uninsured/self-pay patients an estimate of expected charges.

Patient Name: _____ **Date of Estimate:** _____

Service	CPT Code	Qty	Unit Cost	Total
OT Evaluation	97165-67		$300	
OT Treatment - 60 min	97530		$100	
OT Treatment - 45 min	97530		$75	
OT Treatment - 30 min	97530		$60	
			ESTIMATED TOTAL:	**$**

Expected Service Period: _____ **Frequency:** _____

This estimate is valid for 12 months
Actual charges may differ based on needs
You will be notified if costs increase by more than $400

Your Rights: If billed more than this estimate, you may dispute the bill. Contact HHS at 1-800-985-3059 for questions or complaints.

_____ _____
Parent/Guardian Signature Date