Mighty Oaks
CHILDREN'S THERAPY CENTER

Dear Families,

This letter is to inform you of an important policy change which will become effective May 8, 2013. Upon beginning services at Mighty Oaks you agreed to an attendance policy which requires 24 hours notice for cancelling appointments, whenever possible. Unfortunately, in recent months we have begun experiencing a tremendous number of late cancellations (less than 24 hours notice) and No-shows (missed appointments without notice). In order to assure the sustainability of Mighty Oaks, it has been necessary to revise our policy, to reflect the following:

- If your child must miss a therapy appointment due to illness, a conflicting appointment, or for any other reason, please contact our office at (541) 967-7551 at least 24 hours in advance whenever possible. We understand that in the case of illness advance notice may not be possible, and we appreciate your efforts to notify our office as soon as possible. Our voicemail is checked frequently throughout the day, after hours, and over the weekend, so feel free to leave a message.
- If your child misses an appointment without notice (no-show) you will be provided with an attendance warning. If a second appointment is missed without notice your child will be removed from the therapy schedule for all disciplines. You and your child's doctor will be notified in writing of his/her discharge from therapy. If you wish to re-initiate therapy services, you will be charged a $35 non-refundable re-enrollment fee prior to re-beginning therapy, and any subsequent no-shows will result in termination of services.
- If a pattern of late cancellations or late attendance is noted an attendance plan will be put into place. If it is not adhered to, therapy may be terminated.
- Exceptions to the above policies are made for those children who are medically fragile. This determination is made upon the therapist's request and with supporting documentation from the child's physician.
- If your therapy services are terminated, you will then have the option to be placed onto the bottom of the waiting list. Once everyone above you on the list has had the opportunity to receive services, you will be able to start the intake process to once again begin receiving therapy.

My signature below implies that I have read (or had read to me) and understand the above policies. (A copy will be provided for your records upon request)

______________________________ ______________

Parent/Guardian **Date**

______________________________ ______________

Child's Name **Date of birth**

3615 Spicer Dr. SE Albany, OR 97322 phone 541.967.7551 fax 541.967.5095
www.mightyoakschildren.com

Submit by Email

Mighty Oaks Children's Therapy Center
Intake/Referral Form

Referred for:
- [ ] Occupational Therapy
- [ ] Physical Therapy
- [ ] Speech Therapy

Date Completed ______ Completed by: ______ Custody: ______

Child's Name: ______ Date of birth: ______ Age: ______ Gender ______

Mother's Name ______ Father's Name ______ Siblings: ______

Address: ______ City ______ Zip: ______ Home Phone ______

Mom's Work Phone ______ Mom's Cell Phone ______ Message Phone ______

Dad's Work Phone ______ Dad's Cell Phone ______ Message Phone ______

Child's Prim. Lang. ______ Primary Care or Referring Physician: ______ Phone ______

Diagnosis (list all) ______

Primary Insurance ______ Contact Phone ______

Group Number ______ ID Number ______

Secondary Insurance ______ Contact Phone ______

Group Number ______ ID Number ______

How did you hear about Mighty Oaks? ______

Medical History:
- [ ] Pregnancy Complications

Describe: ______

Delivery: ______ [ ] Full Term Birth [ ] Premature Birth # weeks premature: ______

Specific conditions/defects at birth: ______

Has he/she experienced the following (specify approximate date of onset):
- [ ] Allergies ______
- [ ] Asthma ______
- [ ] Seizures ______
- [ ] Encephalitis ______
- [ ] Pneumonia ______
- [ ] Tinnitus ______

Other information pertinent to medical history or current condition: ______

Please list hospitalizations with dates: ______

Current medications, side effects & precautions: ______

mighty oaks

Patient Name: Last, First Middle

Date of birth:

Age:

Sex:

Address:

City:

State:

Zip:

Phone Number

Message Number:

Mother/Guardian Name

Phone:

Work:

Address:

City:

State:

Zip:

Father/Guardian Name:

Phone:

Work:

Address:

City:

State:

Zip:

If in foster care, please give name and phone # for caseworker:

Please list full name of all members of your family at home:

Name:	Date of Birth:	Name:	Date of Birth:
Name:	Date of Birth:	Name:	Date of Birth:
Name:	Date of Birth:	Name:	Date of Birth:
Name:	Date of Birth:	Name:	Date of Birth:

Please list a friend/relative (not living with you) to contact in case of emergency:

Name:

Relationship:

Address:

City/State:

Phone:

Assignment of Benefits:

I have completed this application accurately and to the best of my knowledge. I hereby authorize payment of benefits to be made directly to Mighty Oaks Children's Therapy Center for services provided to me (or my child) by the agency. I understand that I am financially responsible for charges not covered by insurance. I authorize refund of overpaid insurance benefits where my coverages are subject to coordination of benefits. In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees.

Signature of Parent/Guardian:

Date:

Authorization for release of medical information:

Primary Care Physician: | Date of Authorization: | Initials:

Insurance: | Date of Authorization: | Initials:

Other (specify): | Date of Authorization: | Initials:

I authorize Mighty Oaks Children's Therapy Center to photograph my child: ☐ Yes ☐ No

I give permission to have observers present during therapy, for the purposes of demonstrating services for educational, informational, or promotional purposes: ☐ Yes ☐ No

Mighty Oaks Children's Therapy Center may use my child's name: ☐ Yes ☐ No

Signature:

Date: