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# INTAKE AND EVALUATION REFERRAL FORM

Abbie V. Woodard (Hurst), MS CCC-CLP, Inc., North Florida Therapy Services (NFTS), Inc., North Florida Mental Health (NFMH), Inc., hereinafter collectively referred to as NFTS, provides speech-language therapy, occupational therapy, physical therapy, Applied Behavior analysis (ABA) and mental health therapy services to children of all ages. Children must be evaluated to determine if services are needed to address any delays in development or maladaptive behaviors. You will be informed of the results of these evaluations. Please be aware that pediatric therapy is mostly provided through the use of play-based activities. As in regular play, minor falls, bumps, and scrapes may occur when a child is participating in therapy.

North Florida Education Services (NFES), Inc. provides an inclusive private school education to children from kindergarten through 8th grade who may require additional support or specialized instruction.

Please complete this form by providing the required information listed below:

Child's Name: _____Nickname: _____

Date of Birth: _____ Gender: Female Male

Address: _____

Parent/Guardian 1: _____

Phone Number: _____ Email:_____

Parent/Guardian 2: _____

Phone Number: _____ Email:_____

Primary Physician: _____

Insurance:_____ Policy Number:_____

Insurance Phone Number:_____

Allergies: _____

Diagnosis:_____

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Primary concern/reason for requesting evaluation: _____

_____

Medical Conditions: _____

Daycare Facility/School child attends (if any):_____

Emergency Contact 1: _____

Phone Number: _____ Email:_____

Emergency Contact 2: _____

Phone Number: _____ Email:_____

Authorized to Pickup: _____

Additional Information: _____

_____

**CONSENT FOR EVALUATION/TREATMENT**

Yes, I do voluntarily consent for my child to receive Occupational Therapy (OT), Physical Therapy (PT), Speech Therapy (ST), Applied Behavior Analysis (ABA), and/or Mental Health (MH) assessments and/or treatments as deemed appropriate.

_____*please initial*

*I do not wish for my child to participate in any of the following:* _____
*(If you consent to all, leave blank)*

**CONSENT FOR OBSERVATION**

Occasionally, NFTS, NFES, and its affiliates, may have students from colleges and universities, other professionals, or individuals interested in the field request observation of therapy sessions or classroom instruction.

Yes, I do voluntarily consent for my child's session and/or classroom to be observed by a student, cleared by NFTS and NFES, for purposes of education. NFTS and NFES do background screenings and require volunteer forms explaining HIPAA to be signed prior to any sort of observation.

_____*please Initial*

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## CONSENT FOR RELEASE/DISCLOSURE OF INFORMATION

You are giving your consent to receive treatment services. Please be informed for services to be rendered, you are giving consent for NFTS and NFES to release medical and treatment records to your physician, specialist, insurance company, or any other affiliated parties in need of this information and to discuss your child with any of these professionals for any and all medical and treatment related matters.

NFTS and NFES employees may also share information with each other internally to ensure the highest quality of care and support for your child. NFTS and NFES will maintain compliance with all applicable HIPAA regulations and will not disclose information to unauthorized parties.

Yes, I do voluntarily consent to release medical and treatment records to necessary parties and/or discussion of my child with other professionals.

_____*please initial*

****Please see accompanying HIPAA Notice and signature form*

## OUTPATIENT APPOINTMENT POLICIES

I understand that NFTS requires cancellation of appointments at least 24 hours in advance. We understand that this is not always possible due to illness or emergency, however, repeated no-shows, no-calls, or frequent late arrivals will lose their place on the schedule and may be discharged from further services.

_____ *please initial*

I understand that NFTS front desk staff cannot provide supervision for my child. If I arrive more than 10 minutes early for my child's scheduled appointment time, I understand I must wait in the lobby with my child until their therapist comes to get them.

_____ *please initial*

Additionally, if I arrive more than 10 minutes late to pick up my child from their appointment, NFTS reserves the right to revoke drop-off rights, and I will be required to wait in the lobby during my child's appointment or I will be charged the daily drop-in rate for childcare fees ($25).

_____ *please initial*

## CONSENT FOR VIDEO/PHOTO RELEASE

NFTS, NFES, and its affiliates have the right to use my child's image/video or likeness in print, online platforms, presentations, and/or social media. I further understand I will not be compensated for use.

*Please initial one:*

_____Yes, I voluntarily consent for my child's image to be used.

_____ No, I do not wish for my child's image to be used.

## MANDATORY REPORTERS

A mandated reporter is bound by law, because of their profession, to report any suspicion of child abuse or neglect to the relevant authorities in the best interest of the child. All employees of NFTS and NFES are mandated to report abuse and neglect or suspected abuse and neglect. We do not take our job or this stipulation lightly and are knowledgeable of the laws and regulations related to mandated reporting requirements.

I understand all employees and subcontractors of NFTS and NFES are mandated reporters and are required to report any suspicion of abuse or neglect.

_____ *please initial*

North Florida Therapy Services

**HOLD HARMLESS/INDEMNITY WAIVER**

NFTS and NFES provide specialized treatment and education programs for children with a wide range of abilities and challenges. Due to the nature of these services and the potential for challenging behaviors, there is an inherent level of risk involved while children are in our care.

By signing this agreement, I hereby release and hold harmless Abbie V. Woodard, MS CCC-SLP, Inc; NFTS, Inc., NFMH, Inc, D/B/A North Florida Therapy Services, NFES, Inc., and the owner, Abbie Hurst, F/K/A Abbie Blackman, F/K/A Abbie Woodard, from any liability, claims, demands, and causes of action, now or in the future, related to any injury or incident, however caused, that may occur after I have relinquished my child into their care for the purposes of treatment and/or education.

I acknowledge that this waiver is intended to cover all risks associated with participation in services provided by NFTS and NFES.

I voluntarily agree with the terms of this Hold Harmless / Indemnity Waiver.

_____ *please initial*

****Please see accompanying Hold Harmless Agreement and Release of Liability Waiver signature form*

By signing this agreement, I acknowledge that I understand and consent to all items referenced in this agreement.

_____ _____

*Parent/ Guardian's Signature* *Date*

_____

*Parent/Guardian's Printed Name*