Jane Gatanis, OTR/L, LLC
145 4th Ave. #14E, NYC NY 10003
JaneGatanisLLC@gmail.com

Infant / Birth – Age 2 History

Date: _____

General Information:

Child's name: _____

Parent name: _____ Phone: _____

Parent name: _____Phone: _____

Address: _____

Preferred Email: _____

Pediatrician: _____

Referred by: _____

Medical issues/procedures: _____

Current medications: _____

Prenatal Health of Mother:

Medical issues: _____

Genetic testing: _____

Medications: _____

Stresses:_____

Exercise: _____

Difficulty conceiving: _____

Family history of allergies / sensitivities: _____

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Birth:

Conception: _____

Interventions (forceps, vacuum, epidural, caesarean): _____

Type/Duration of delivery:_____

Location of delivery (hospital, home, birthing center):_____

Support staff (midwife, doula):_____

Please add any information: _____

_____

Feeding:

Breastfeeding/bottle: _____

Quality of latch and suck :_____

Is feeding easier one side than the other?: _____

Birth weight: _____ Current weight : _____

Additional Information: _____

Digestion:

Colic: Yes No Reflux: Yes No Arching: Yes No Flatulence: Yes No

Quality of elimination: _____

Sleep:

Family bed, crib and patterns: _____

Main goals of therapy: _____

_____

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CLIENT ACCESS AND AUTHORIZATION FORM

Client Name: _____

Parent/Legal Guardian Name: _____

Thank you for choosing Jane Gatanis, M.S., OTR/L, LLC. The service you have elected to participate in carries a financial responsibility on your part. You are responsible for payment in full at the time of service.

I have read the above policy regarding my financial responsibility to Jane Gatanis, M.S., OTR/L, LLC for providing rehabilitative services to the above-named client or me. I agree to pay Jane Gatanis, M.S., OTR/L, LLC the full and entire amount of bills incurred by me or the above-named patient.

Signature: _____ Date: _____

Relationship to client, (please circle): self - guardian – other: _____

DISCLOSURES TO INDIVIDUALS AND HIPAA PRIVACY AUTHORIZATION FORM

There may be times when it is necessary for an individual involved in your care to call me to inquire about your personal health information or billing information. Please take a few moments to complete this section.

I authorize Jane Gatanis, M.S., OTR/L, LLC to use and disclose my health information that is related to my current treatment to, (please indicate name, relationship, and other relevant information):

1._____

2. _____

3. _____

4. _____

5. _____

This authorization for release of information covers all past, present, and future periods.

□ **I authorize the release of my complete health record.**

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my

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authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature: _____ Date:_____

Relationship to client, (please circle): self - guardian – other: _____

CONSENT OF TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I voluntarily consent to have Jane Gatanis, M.S., OTR/L, LLC, through its appropriate personnel, provide evaluation and/or treatment. I understand the practice of Occupational therapy and Craniosacral therapy is not an exact science, and I acknowledge that no guarantees have been given to me regarding the successful completion or the results of the treatment provided. I understand that the treatment I receive from Jane Gatanis, M.S., OTR/L, LLC is limited to Occupational therapy services and/or Craniosacral therapy and that I shall seek treatment from other medical professionals for all other issues I may experience. I understand that I have the right to ask questions at any time during the course of my care.

Signature: _____ Date: _____

Relationship to client (please circle): self - guardian – other: _____

I further authorize Jane Gatanis, M.S., OTR/L, LLC to release to appropriate agencies, any information acquired during my, or the above-named, client's examination and treatment necessary to secure payment for services provided.

Signature: _____ Date: _____

Relationship to client (please circle): self - guardian – other: _____

24 HOUR CANCELLATION POLICY

Appointments must be cancelled at least 24 hours in advance to avoid being charged 100% of your visit.

By signing below, you acknowledge that you have read and understand the cancellation policy for Jane Gatanis, M.S., OTR/L.

Signature: _____ Date: _____

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