OCCUPATIONAL THERAPY SERVICES

9810 F.M. 1960 Bypass, Suite 190
Humble, TX 77338

Admission Form
Comprehensive Treatment Plan Agreement

The following is a description of this clinic's policies regarding the comprehensive treatment plan. Please read and indicate your agreement to abide by these policies by initialing and signing where indicated. If you have any questions about these policies please ask a representative of this clinic before signing.

Non Discrimination Policy
The Center does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment. For further information contact our Front Office or TTY State Relay at 1-800-735-2988.

Speech, Hearing and Visual assistance communication guides are available at no charge and upon request. For further information contact TTY State Relay at 1-800-735-2988

Initials _____

Scheduling Policy and Consent to Treat
I, the Patient/Parent or Legal Guardian hereby consent to treatment for therapy services. I further understand that once a weekly treatment appointment schedule has been determined, this clinic is often unable to accommodate changes for temporary periods of time. When a permanent change in time is needed, I must give as much advanced notice as possible for the clinic to attempt to accommodate this request. A change in time may necessitate a change in therapists as well.

I understand that in order to receive maximal benefit from treatment, it is important for treatment to occur each week. I understand that I must give at least 12 hours advanced notice of cancellations, or risk losing my appointment time. Exceptions can be made for emergency situations. I understand that a make up session may occur with a substitute therapist or our regular therapist.

I understand the notification of vacations or family obligations is requested at least two weeks prior to the expected absence, to facilitate rescheduling our appointment(s). I understand that we can make up sessions for vacation time two weeks before or following our vacation time.

I understand that the clinic is open except in cases of severe weather conditions requiring businesses to close. It is my responsibility to call the clinic to determine whether changes in the scheduled time of treatment are needed and if the opening of the clinic has been delayed. Families may cancel treatment if they do not wish to travel in poor weather conditions. I understand that if treatment time falls on a federal holiday then I am encouraged to make up these sessions.

I understand that if our therapist is ill or on vacation, the clinic will provide a substitute therapist to ensure continuation of services. This clinic will make every effort to schedule the therapist at our regularly scheduled appointment time. If this cannot occur, the clinic will provide an alternate appointment time.

I understand that if we do not keep a scheduled appointment or if we do not cancel a session before the session is scheduled to begin, that time of treatment is forfeited.

I have read and agree to abide by the above policies. Initials _____

Name of patient: _____
Medicaid#: _____