Alyssa Frey, M.S., OTR/L, LLC
509 Valley St. Maplewood, NJ 07040
info@alyssafreycst.com

TEEN AND YOUNG ADULT INTAKE FORM (age 13+)

General Information

First and Last Name: _____

Age: _____

Address: _____

Phone number: _____

Email: _____

Medical History

Childhood Illnesses:

_____

_____

Medical History:

_____

_____

Past accidents/surgeries/traumas (emotional and physical):

_____

_____

Current stressors:

_____

_____

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In case of emergency call: _____

Physician: _____

Referred by: _____

Other therapies (traditional and non-traditional)

_____

_____

Medications, Vitamins, Supplements

_____

_____

Exercise & Nutrition:

_____

_____

Personal goals for therapy:

_____

_____

_____

(Signature of client – *To sign, enter first and last name*)

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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 Alyssa Frey, M.S., OTR/L, LLC to use and disclose health information 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 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: _____

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CONSENT OF TREATMENT AND AUTHORIZATION TO RELEASE

I voluntarily consent to have Alyssa Frey, M.S., OTR/L, LLC, 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 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.

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

Signature: _____

Relationship to client (e.g., parent, guardian) _____

Date: _____