Welcome to SdW Therapy Services, before we begin our therapy journey, please find below a little bit about the company and how we work.

SdW Therapy Services is owned and operated by Sally de Wijn and was established in 2015 and is rapidly growing. We are a family friendly clinic who understand the work of busy parents and families – we all have one ourselves.

We believe that each child is able of succeeding in what they want to, it is just that they need the time and a strong unconditional relationship with someone (other than parents) who believes they can do it.

We have combined two therapies into one, we use the fundamentals of both Occupational Therapy and Child Centred Play Therapy, using a non-directive approach to facilitate children achieve their goals.
Our practice looks like we are just playing with the child and that is exactly what we want, as we know this is the post powerful learning for a child.

We currently have a of four OT's and a music therapist who look forward to working with you.

Referral pathway to see a therapist at SdW Therapy Services:
While a referral is not needed, there are some initiatives that can allow for a rebate or cover the cost of sessions.
Referrals can be made under the following initiatives:
Medicare – Chronic Disease Management
Medicare – Better Access to Mental Health
Medicare – Helping Children with Autism
Medicare – Better Start for Children with Disabilities

Sessions can be claimed in full under the following initiatives:

DSS – Helping Children with Autism
DSS – Better Start

National Disability Insurance Scheme
Self-Managed
Plan Managed

**Please note we do NOT accept Agency managed NDIS participants, due to the high cost involved in maintaining registration with the NDIA for these clients, we prefer to ensure our cost of service is kept low so that all clients regardless of funding bodies can access our services.*

Private Health Funds
A portion of sessions may be claimed under Private Health

Thank you for choosing SdW Therapy Services, we all look forward to working you and your family.

SdW Therapy Services Team.

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fax: 03 8640 0417
e:letsplay@sdwtherapyservices.net
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Clients Details

Child's Name:				**Date of Birth:** ____ /_____ /_____	
Parents/Carers:		**Custody arrangements (if any)**			
		Is there a court order in place?		**Y/N** **If yes please attach a copy**	
Residential Address:					
Parent Mobile Number:		**Parent Email address:**			
Aboriginal /Torres Islander	**Y/N**	**Language/s spoken at home:**			
Country of birth:		**Interpreter required**	**Y/N**	**If Yes Language**	

Past Reports		
Type of Report	**Date**	**Score/result**

Funding Details					
☐ FaHSCIA (HCWA)	☐ Better Start	☐ Medicare	☐ Private	☐ NDIS: **Please attach a copy of NDIS plan**	☐ Self-Managed ☐ Plan managed *please note we **do not** see NDIA managed Clients

NDIS Plan Management Details	
Plan manager	
Email address	
Phone Number	

School/Kindergarten/Childcare	
Name	
Address	
Phone Number	

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Payment Policy:
Please be aware the payment for services will be required **3 working days** from Invoice sent date
If payment is not received within **3 working days** (without prior arrangement) late payment fees may apply.
If you require a payment plan for services this can be arranged and will be agreed upon by both parties.

Initials

Credit Card Authorisation

It is policy for SDW Therapy Services collect credit card details from all clients so that if in the event that fees are not paid within 14 days of invoices being sent, fees will be collected by via this payment method, a $40 late payment fee, as well as the processing fee will be added to client's invoice at this stage.

Credit Card Details: Name on Card:

Card Number __ __ __ __ / __ __ __ __ / __ __ __ __ / __ __ __ __Expiry __ __/__ __ CVC _ _ _

OR

My credit card details have been provided to my therapist and have been encrypted into Health Kit (client management system),
As the owner of the card number above I authorise payments to be collected if I am unable to pay my invoice within 14 days sent date. I also understand that a late fee of $40 will be added to the invoice.

Card holders Signature: Date:

Medicare Claiming:
If you are unsure that the correct referral information is on this invoice please check before claiming from Medicare
Once invoices are claimed through Medicare no changes to invoices will occur.

Initials

Cancellation policy:
A cancellation policy is a standard and necessary policy in the health industry. By signing this document, the client acknowledges these terms and agrees to the resulting actions. In the case of lack of attendance, the following procedure will be followed:
If the participant is unable to attend a session, and gives the provider under 24hs' notice, 90% of session fee cancellation fee will be charged. In exceptional circumstances the provider may agree to waive this fee.
If the participant fails to attend a session without giving any notice, the full session fee will be charged.
In instances where cancellation fees are not paid, particularly in repeat instances, future sessions may be suspended until they are paid.

Initials

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Feedback, complaints and disputes

It is important to SdW Therapy Services that you are receiving the service and assistance that you want; therefore, we welcome your feedback as we are to work with you to deliver a service you are happy with.
If you are unhappy with your service please first speak with your therapist, hopefully the problems can be resolved.
If you are unhappy with the outcome, you have the right to make a complaint, and seek an advocate to assist in this area.
To do so you can contact the relevant bodies below:

- Disability Services Commissioner (DSC) 1800 677 342
- Equal Opportunity and Human Rights Commission 1300 981 848
- OTA – Occupational Therapy Australia
- AHPRA – Australian Health Practitioner Regulation Agency
- Medicare
- NDIA– National Disability Insurance Scheme
- Department Social Services (formally FaHSCIA)

If you require an advocate agency can be found by using **The National Disability Abuse and Neglect Hotline 1800 880 052 or** hotline@workfocus.com.

Initials

Privacy Policy:

All information obtained by the practitioner will be kept confidential and not disclosed without appropriate consent or where mandated by law this is in accordance to the Privacy Act Amendment (Private Sector) Act 2000 and the ten National Privacy Principles (NPPs) contained in schedule 3 of the Privacy Act 1988 (Privacy Act).
I am aware that information will be disclosed required by law and that if there is a breach of privacy I (the family) will be informed as well as DHHS.

Initials

Photo Consent Form for Occupational Therapy

I (Parent Name(s)) hereby give consent to SdW Therapy Services or Hired Photographer of SdW Therapy Services to take photos(s) of my child: (Child' s Name(s))

For the purpose of: (please tick if you are happy for photos to be used for these purposes)

- ☐ **To be provided to Parents to see what children have done during session using See Saw app**
- ☐ Promotion of Group Therapy through FACEBOOK
- ☐ Promotion of Group Therapy through WEBSITE
- ☐ Promotion of Group Therapy Through Flyers
- ☐ Promotion of Group through WORKSHOPS AND SEMINARS within the surround areas

I understand that:

- My child's name will not be published with any photos
- It is my right to withdraw this consent at any time
- Photos will be shown to me before used for promotional purposes

Parent/Guardian Signature: Date:

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Fee Schedule

Initial Consultation		
50 mins therapy 10 mins notes (Below NDIS Fee Schedule)	Total Cost	$190*
Ongoing Consultation		
50 mins therapy 10 mins notes (Below NDIS Fee Schedule)	Total Cost	$180*
Assessment		
1-1.5 Hours of relevant assessment written report, provided as PDF via email	Total Cost	$600#
Written Report		
Total Cost		$190*
Group Sessions Termly Rate		
1.5hr x weeks in term	Paid per term	$88.50 x wks in term*
2hr x weeks in term	Paid per term	$118 x wks in term*

Phone Consultation * pro- rata		
Up to 15mins	Total Cost	$40*
15-30 mins	Total Cost	$80*
30-60 mins	Total Cost	$180*
Cancellation of session after 3pm day before session or 'no show'		
90% of session fee		
Late Payment (not paid within 3 working days of invoice sent)		
$40 charged by external company		

Non-Clinical Client time		
60mins	Total Cost	$180# (pro rata)

Travel Costs per session# – see map attached			
0-5kms	$15 per session	15-20kms	$60 per session
5-10kms	$30 per session	20-25kms	$75 per session
10-15kms	$45 per session	More than 25kms	$95 per session

*effective 1st April 2020 # effective 1st July 2020

Please note that these fees and charges are subject to change according to the discretion of the provider, SdW Therapy Services. If changes are to be made 4 weeks' notice will be given.

My signature below affirms that:

- I have read and understand the fees above, and that I voluntarily consent the payment of fees as stated above, I understand that fees will be reviewed annually, I can make complaints about fees as outlined in complaints section of this document

Parent/Guardian Signature: Date:

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5KM
10KM
15KM
20KM
25 KM
Melton
Melton West
Brookfield
Toolern Vale
Plumpton
Rockbank
Eynesbury
Mount Cottrell
Diggers Rest
Sunbury
Gisborne
New Gisborne
Gisborne South
Bullengarook
Lerderderg State Park
Coimadai
Merrimu
Darley
Bacchus Marsh
Parwan
Rowsley
Balliang East
Balliang
Quandong
Mambourin
Werribee
Hoppers Crossing
Tarneit
Truganina
Ravenhall
Derrimut
Deer Park
Caroline Springs
St Albans
Taylors Lakes
Bulla
Melbourne Airport
Tullamarine
Broadmeadows
Coolaroo
Roxburgh Park
Oaklands Junction
Craigieburn
Mickleham
Wildwood
Clarkefield
Essendon
Sunshine
Footscray
Altona North
Altona
Altona Meadows
Laverton
Williamstown
Point Cook
Barrys Reef
Blackwood
Dales Creek
Greendale
Korobeit
Myrniong
Ballan
Pentland Hills
Ingliston
Beremboke
Staughton Vale
Anakie
C318
C704
C705
C708
M79
C743
C325
C706
C705
C754
C701
M8
C702
C703
C109
C723
M31
C722
C739
M80
M1
M2
Map data ©2020

CONFIDENTIAL MEDICAL INFORMATION

Name:……Date of Birth:……../……./……..

Home Address: ……

Home Telephone: ……

Medicare Number: ……

Medical/Hospital Insurance:

Name of Fund:……Membership Number: ……

Ambulance Fund: Yes/No If yes, Membership Number: ……..

If No, do you authorise facilitators to call an ambulance if they deem necessary for you child? Yes/No

Family Doctor: Name:……..……Telephone: ……..……

Do you have a pre-existing medical condition? Yes/No If yes, please provide details:

……..…… ……

Are you presently taking any medication? Yes/No If yes, please provide details:

……..…… ……

Do you have any allergies (eg foods, medications)? Yes/No If yes, please provide details:

……..…… ……

Tetanus Immunisation:
Date of last immunisation: ……/……/……

EMERGENCY CONTACT DETAILS:
Name: …… Relationship: ……

Contact Telephone Number:
Business:…… Home:……

- This information is to assist medical staff in the event of an emergency.
- All information will be held in confidence will be passed intact to ambulance/medical staff only in the event of a medical emergency.
- This form will be supplied to emergency services if needed

By signing I agree to the above information is correct as well as agree to the above clauses.
Parent Name: ……..

Parent Signature: ……..Date: ……/……./……

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Release of Information Consent Form

I (Parent Name(s)) give permission for SdW Therapy Services to have contact with the following persons, professionals and agencies, to provide and receive information in relation to my child and their therapy needs.

School/kindergarten/childcare	
Name:	
Contact:	
Phone:	
Email:	
Paediatrician	
Name:	
Contact:	
Phone:	
Email:	
Psychologist	
Name:	
Contact:	
Phone:	
Email:	
Speech Pathologist	
Name:	
Contact:	
Phone:	
Email:	
Other	
Name:	
Contact:	
Phone:	
Email:	
Other	
Name:	
Contact:	
Phone:	
Email:	

I understand that at any time, I/We can revoke this agreement and withdraw permission for contact with the above listed people.

Parent/Guardian Signature: Date:

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Child Profile

Please fill in the below this will help us understand more about your child and their needs.

Child name:
Diagnosis (where applicable):

Communication
Describe the child's ability to communicate, (how do they do this?) Are they verbal or non-verbal? Where applicable, describe any strategies or technique in place that supports the child in this area.
Self Help
Please provide information regarding any self-help support your child may require. Eg. Serving/eating food, toileting, transitions between inside and outside, selecting activities.
Social Emotional
Describe your child's social interactions with others including understanding of social behaviour.
Describe your child ability to identify and express of frustration/anger, including any known triggers and strategies.

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Physical
Please provide information regarding any mobility support to therapist's awareness your child may require. Eg. Gross and fine motor skills, muscle tone, coordination.

Sensory
Does your child have any sensory areas the service should be aware of? Consider both heightened and lowered sensory in areas of vision, sound, tactile/environment.

Cognitive
Describe your child's focus of attention and concentration span. Consider the child's ability to follow instruction, recall information and recognise danger.

Triggers
Please provide information regarding any triggers our therapists should be aware of.

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Calming Strategies
Please provide information regarding any calming strategies our therapists should be aware if child is overwhelmed of in the event of a meltdown.
Other
Please highlight any information you feel is relevant for the therapists at the service to be aware of.

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