**Power Play – All Hands on Deck 2024 Pediatric Bimanual Summer Camp**

Led by our pediatric occupational therapists, All Hands on Deck is a multi-week program that focuses on improving the use of two hands together to perform functional tasks in children who have spastic hemiplegia or hemiparesis as a result of cerebral palsy, traumatic brain injury, stroke or other diagnoses. This program utilizes principles of Bimanual Intensive Training in which all activities require the use of two hands to complete. The focus is on encouraging the affected arm to be the best possible assisting hand during everyday tasks.

Camp activities include games, art projects, sports, outings, and self-care. Children will be evaluated at the beginning and end of camp to progress in functional use of two hands together.

Dates: Monday through Thursday, July 22nd – August 8thTimes: 1-4pm (7-10+ years old)

**Criteria:**

Participants must be:

* Ambulatory-able to walk and move around independently
* Able to spontaneously use their affected limb
* Toilet trained and able to use the bathroom independently

**A physician referral/prescription is required to participate in the camp. Participants must have an insurance policy that will cover group therapy.**

Please contact your insurance company to inquire if your child’s benefits cover “group therapy” code: 97150. For more information on insurances we currently accept, please see our website: <https://www.sralab.org/contact/insurance>. Here you will also find the numbers to contact for patient financial services and our managed care teams. Parents are required for knowing insurance limitations with therapy coverage.

|  |  |  |
| --- | --- | --- |
|  | YES | NO |
| I have checked my insurance and it does cover group therapy code 97150 |  ☐  |  ☐  |
| I **HAVE** used other therapy benefits elsewhere |  ☐  |  ☐  |
| If checked yes to the previous question, please use this line to enter how many visits have been used elsewhere. Family is responsible for knowing their max visits.  | Visit Number: |  |
| I understand that I am liable for any additional charges that my insurance does not cover |  ☐  |  ☐  |
| I **HAVE** a visit limit  |  ☐  |  ☐  |
| If checked yes to the previous question, please use this line to enter how many visits are allowed. Family is responsible for knowing their max visits. | Number of visits: |  |
| Max amount of units allowed per day  | Unit number allowed: |  |

Patient Full Name Patient DOB

Printed Parent Name Parent/Legal Guardian Signature

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**Please print and complete all entries**

Patient Name: Patient Birth Date:

Address: Caregiver Name:

Home Phone: Cell Phone:

Caregiver Email:

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Primary Doctor/Pediatrician:

Ordering Physician (for camp):

Emergency Contact: Relationship:

Phone Number:

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**Insurance Information Insured/Responsible Party**:

Relation to Patient:

Birth Date:

Address (if different from patient):

 **Primary Insurance:**

Address:

Phone Number:

Group Number: ID Number:

 **Secondary Insurance:**

Address:

Phone Number:

Group Number: ID Number:

 **Additional Information:**

Is your child currently receiving occupational therapy (OT)? [ ] YES OR [ ] NO

Can you attend dates of camp July 22nd – August 8th [ ] YES OR [ ] NO

Please list patient’s interests and hobbies: