



APPLICATION FOR SERVICES

Patient Information:

Name: _____ DOB: _____ Gender: M / F

Address: _____

Home Phone: _____ Cell Phone: _____ Mobile Carrier: _____

Can we leave a message regarding appointments on your home and mobile phone(s)? Y / N

Primary Care Physician: _____ Practice Name: _____

Email Address: _____ Services Requested: _____

Reason for requesting services (be specific about any concerns): _____

Is your child receiving PT / OT / SP services elsewhere? Y / N If yes, where? _____

Are those services being billed to your insurance company? Y / N

Responsible Payer Information:

Name(s): _____

Relationship to Patient: _____

Address: _____

Email: _____

Phone: _____

Social Security #: _____

Billing Information (Please list all):

NO INSURANCE

Primary Insurance: _____

Secondary Insurance: _____

ID #: _____

ID #: _____

Policy Holder's Name: _____

Policy Holder's Name: _____

Policy Holder's DOB: _____

Policy Holder's DOB: _____

In the event of an emergency, please contact:

Name	Relationship	Home Phone	Work or Cell Phone

I give permission to Reach for the Top Therapy Services to administer medical aid or to seek and have aid provided from a qualified medical professional if the situation requires it.

Parent/Legal Guardian Signature

Date

Relationship to Patient

Who lives in your home?

Name	Relationship	Age

Are there pets at home? Y / N If Yes, What kind: _____

Complications during mother's pregnancy, labor and delivery? Y / N If Yes, please describe: _____

Birth Order: _____ **Birth Weight:** _____ **Premature / Post Mature / Full Term**

Mark any of the following that your child has had a history of:

- Chronic illness Chronic infections Fever Respiratory issues
- Vision problems Hearing problems Ear infections Heart issues
- Sleeping problems Feeding difficulties Diabetes Seizures
- Meningitis Tuberculosis Neurological issues Orthopedic issues

Other: _____

Describe anything checked: _____

Please list any other illnesses (other than typical childhood illnesses), hospitalizations, surgeries, and physical Injuries your child has had: _____

Are Immunizations up to date? Y / N

Is your child attending early intervention / Head Start / Child Care / School? Y / N If Yes, Where? _____

Grade level? _____ **Does your child have a current IFSP / IEP / 504 Plan?** _____

Does your child receive any services through school? Y / N If Yes, what services? _____

Please indicate other diagnoses your child has received:

Diagnosis	Approximate Date of Diagnosis

Please list other physicians and specialists who provided care to your child:

Name / Location	Specialty	Phone Number

Current Medications:

Name	Dosage	Frequency	Reason for Medication

Any known allergies? Y / N If yes, please list: _____

Is your child on a special diet? Y / N If yes, please describe: _____

Vision tested: Y / N Where: _____ Glasses: Y / N

If yes, date of last vision test: _____ Results: _____

Hearing tested: Y / N Where: _____ Hearing Aids: Y / N

If yes, date of last hearing test: _____ Results: _____

Does your child use any medical equipment? N/A Wheelchair: Y / N Strollers: Y / N Walkers: Y / N

Specialized Equipment: _____

Does your child have orthotics: Y / N If Yes, What kind: _____

Developmental Milestones: Please note approximate age at which your child did the following:

Sat: _____ Crawled; Belly: _____ Hands & knees: _____

Walked: _____ First Word: _____ First sentence: _____

Undressed self: _____ Dressed self: _____ Toilet trained: _____

Managed snaps: _____ Managed zippers: _____ Managed buttons: _____

Tied Shoes: _____ Preferred Hand: L / R

How did you hear about Reach for the Top? _____

Patients Name: _____

DOB: _____

REQUEST AND AUTHORIZATION FOR TREATMENT: I hereby request and authorize the Therapist of Reach for the Top Therapy to administer all diagnostic and treatment procedures and / or services as is required for the above named client. **(Initial)** _____

RELEASE OR INFORMATION: I further authorize the release of medical and other information necessary for completion of my claims, if any; in relationship to, insurance or compensation benefits. **(Initial)** _____

Notice of Privacy Practices (HIPAA Acknowledgement/Consent): I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Reach for the Top Therapy. In addition, I hereby consent to the use and disclosure of my child’s personal health information for the purpose of treatment, payment, and health care operations. I understand that Reach for the Top Therapy also serves as a training facility and at times other therapists may be observing, handling, or have access to my child’s medical information. I authorize Reach for the Top Therapy to obtain medical records and/or professional information from my child’s physician or other medical professionals as it relates to my child’s treatment.

I have read and understand Reach for the Top Therapy’s Notice of Privacy Practices:

Parent/Legal Guardian Signature

Date

Relationship to Patient

Please initial the following statements that you are in agreement with:

I agree to allow Reach for the Top Therapy staff to send email reminders to the email address I have provided.

Email Address: _____ **(Initial)** _____

I agree to allow Reach for the Top Therapy staff to text appointment reminders to the cell phone I have provided.

Cell Phone #: _____ **(Initial)** _____

I understand Reach for the Top Therapy Clinic supports students in a wide variety of fields. I agree to allow students to observe / shadow sessions with my child’s treating therapist. **(Initial)** _____

I will not use my cell phone and or any electronics when I am in the therapy gym, unless specified by the therapist for home. **(Initial)** _____

I hereby authorize Reach for the Top Therapy to take photographs, videotapes, or video recordings of my child. Photographic, audio or video recordings may be used for the following purpose: conference presentations, education, staff development, marketing, social media post and grant applications. **(Initial)** _____

Patients Name: _____

DOB: _____

Financial Agreement

Patients approved for therapy services are responsible for any and all charges not paid for by insurance (Medicaid, private insurance, etc.). By signing this financial agreement, you are acknowledging that you understand this condition of service and commit to promptly paying Reach for the services. Following receipt of your monthly patient statement, please contact our practice to make payment arrangements. We accept cash, personal checks and credit cards. We also make credit card pre-payment arrangements for anticipated monthly patient balances. We also are willing to make reasonable payment arrangements to keep your account current.

“No shows” impact on child’s progress and staffing. As such any “no shows” will require a fee of \$25.00 dollars to reinstate services. (Initial) _____

I hereby authorize Reach for the Top Therapy Services to furnish all information to insurance carries and / or Medicaid concerning (Patient’s Name) _____ diagnosis and or treatments. I hereby assign to Reach for the Top Therapy Services (providers) all payment for therapy and related services rendered to my dependents. **(Initial) _____**

I understand that I am responsible for any amount not covered by insurance: this includes but not limited to: Deductible, copayments, co-insurance, and denied services. **(Initial) _____**

I understand that I am responsible for notifying Reach for the Top Therapy of any changes in my insurance coverage. **(Initial) _____**

If I am delinquent in updating this information and charges are denied, I understand that I am responsible for these charges. **(Initial) _____**

I give my consent for Reach for the Top Therapy Services to appeal claims to my insurance company on my behalf. **(Initial) _____**

I give my consent for Reach for the Top Therapy Services to appeal authorizations to my insurance company on my behalf. **(Initial) _____**

Would you like to receive your bills via email? **YES / NO**

My signature below indicates that I am the parent / legal guardian of this patient and that I understand and accept this policy.

Parent / Legal Guardian printed name

Relationship to Patient

Parent / Legal Guardian Signature

Date

Patients Name: _____

DOB: _____

Attendance Policy

Welcome to Reach for the Top Therapy.

Thank you for choosing Reach for the Top for your child’s therapy services. Our entire team is committed to providing you and your family with professional services and timely information needed for your child to progress toward their therapy goals. For success, there needs to be consistency in attendance. We therefore expect your commitment to consistent attendance.

If you must cancel a therapy session, we ask that you call us as far in advance as possible.

Reach staff has developed specific procedures to clarify our expectation of your attendance. We ask you to follow the procedures listed below.

- I understand that consistent attendance of scheduled therapy sessions is critical for improvement and progress
- I believe that my schedule allows me to be compliant with my child’s therapy program
- I will notify Reach for the Top Therapy of planned absences or vacations in advance
- I will phone Reach for the Top Therapy before my appointment time if I am unable to attend my therapy session. If I do not call, my absence will be considered a “no show”
- If you “no show” for a scheduled appointment, you will be required to call us before your child is placed back on the schedule. Please note that we have a wait list and another child will be scheduled in that space
- Patients may be discharged from their therapy program following two (2) unexcused absences and / or “no shows”.

Thank you in advance for your cooperation.

Parent / Legal Guardian printed name

Relationship to Patient

Parent / Legal Guardian Signature

Date

Appointment Preference Request

Please, indicate below your three day and times choices for your child’s therapy appointments. If you are flexible, please indicate whether you prefer scheduling during mornings hours (AM) or afternoons (PM). Please understand that we cannot guarantee your preferences; however, we will try our best to accommodate your needs. Thank you.

1. _____
(Day)

(Time)

2. _____
(Day)

(Time)