Reach for the Top Therapy Services

The McConnell Center
61 Locust Street #331
Dover, NH 03820

Phone: 603-740-3534
Fax: 603-740-3684

Patient Update Form:

Patient's name: _____ DOB: _____

Address: _____

Phone number: (H) _____(C) _____

Legal Guardian(s) names: _____

Email Address: _____

Primary Physician:_____

Primary Insurance: _____

Policy number: _____

Policy holder's name: _____ DOB: _____

Secondary Insurance: _____Policy number: _____

Responsible Party's name: _____

Allergies: _____

_____

Any update in medical history within the last 6 months: _____

_____

Would you like to receive your bills via email? Yes _____ No _____

In the event of an emergency, please contact:

Name	Relationship	Home Phone	Work or Cell Phone

I give permission for 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.

_____ _____ _____

Signature of Parent/Legal Guardian **Date** **Relationship to Patient**

I,_____, as the parent/legal guardian of _____, give permission for _____ (Name of person bringing patient to or picking up patient from appointment) _____ (Relationship to patient) to bring and or pick up my child from Reach for the Top.

I,_____, as the parent/legal guardian of _____, give permission for _____ (Name of person bringing patient to or picking up patient from appointment) _____ (Relationship to patient) to bring and or pick up my child from Reach for the Top.

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

RELEASE OF INFORMATION: I authorize the release of medical and other information necessary for completion of my claims, if any; in relation 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. In addition, I hereby consent to the use and disclosure of my child's personal health information for the purposes of treatment, payment, and health care operations. I understand that Reach for the Top also serves as a training facility and at times other therapists may observe, handle, or have access to my child's medical information. I authorize Reach for the Top 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's Notice of Privacy Practices:

_____	_____	_____
Signature of Parent/Legal Guardian	**Date**	**Relationship to Patient**

Please initial the following statements that you agree with:

I agree to allow Reach for the Top to send email to the email address I provided above.	**(Initial)** _____
Reach staff encourage families to attend each session with their child, to learn strategies to use at home and participate in their care. If a family must leave the session, they **must return at least five minutes before the end of the session**. Parents must also be readily available by phone if an emergency were to occur. Please confirm times with your therapist before you leave your child with them.	**(Initial)** _____
I understand Reach for the Top Therapy Services supports students in a wide variety of fields. I agree to allow students to observe / shadow / provide services under direct supervision of my child's treating therapist.	**(Initial)** _____
I will not use my cell phone and / or any electronics when I am in the therapy clinic, unless specified by the therapist.	**(Initial)** _____
I authorize Reach for the Top to take photographs, video / auto recordings of my child. Photo graphics, audio or video recordings may be used for the following purposes: conference presentations, education, staff development, marketing, social media posts and grant applications.	**(Initial)** _____

Financial Agreement

Patients approved for therapy services are responsible for all charges not paid for by insurance. 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 and/or Cancel without 24hr notice" impact on child's progress and staffing. As such, any "no shows or cancel without notice" will require a fee of $25.00 dollars to reinstate services. **(Initial)** _____

I authorize Reach for the Top to bill and receive all payments for therapy and related services. **(Initial)** _____

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

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

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

_____ _____

Signature of Parent / Legal Guardian **Date**

Attendance Policy

For your child's success there needs to be consistency in attendance. Our commitment along with your commitment every week is vital. If you must cancel a therapy session, we ask that you call us as far in advance as possible. Please see rules outlined below:

- **I understand that consistent attendance of scheduled therapy sessions is critical for improvement and progress.**
- **My schedule allows me to be compliant with my child's therapy program.**
- **I must notify Reach for the Top of planned absences or vacations in advance.**
- **If I am unable to attend my therapy session, I must notify Reach at least 24 hours before the appointment time. If I do not notify Reach by phone or the email alert, my absence will be considered a "no show".**
- **We reserve the right to charge a $25 fee for an appointment that is a no show / or cancelled less than 24 hours prior to the appointment with no attempt to reschedule or attend teletherapy.**
- **Patients may be discharged from their therapy if attendance falls below 50% within a month.**
- **Patients will be discharged from their therapy program following 1 no show.**

Thank you in advance for your cooperation.

_____ _____

Signature of Parent / Legal Guardian **Date**