Reach for the Top Therapy Services

NEW PATIENT INTAKE PACKET

Patient Information:

Name: _____ **DOB:**_____ **Gender:** M / F / U

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

Billing Information (Please list all):

☐ **NO INSURANCE**

Primary Insurance: _____

ID #: _____

Policy Holder's Name: _____

Policy Holder's DOB: _____

Secondary Insurance: _____

ID #: _____

Policy Holder's Name: _____

Policy Holder's DOB: _____

Responsible Payer Information:

Name(s): _____

Address: _____

Phone:_____

Relationship to Patient: _____

Email: _____

Social Security #:_____

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 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.

_____ _____ _____

Signature of Parent/Legal Guardian **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:** _____

How many hours does your child sleep?_____

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 **Standers:** 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? _____

REQUEST AND AUTHORIZATION FOR TREATMENT: **(Initial)**

I authorize Reach for the Top to administer all diagnostic and treatment procedures and / or services as required for the above-named client. _____

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 Therapy's Notice of Privacy Practices:

_____ _____ _____

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

Please initial the following statements that you agree with:

(Initial)

I agree to allow Reach for the Top to send email to the email address I provided above. _____

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 / audio 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 24 hrs 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

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.**
- **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.**
- **I must phone the Reach for the Top clinic 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 or cancel without 24hr notice" for a scheduled appointment, you will be required to call Reach to pay your $25.00 fee before your child is placed back in the schedule. If you do not call, another child will be scheduled in that space.**
- **Patients will be discharged from their respective therapy services following 2 "no shows".**

Thank you in advance for your cooperation.

_____ _____

Signature of Parent / Legal Guardian **Date**