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: _____ **Secondary Insurance:** _____

ID #: _____ **ID #:** _____

Policy Holder's Name: _____ **Policy Holder's Name:** _____

Policy Holder's DOB: _____ **Policy Holder's DOB:** _____

Responsible Payer Information:

Name(s): _____ **Relationship to Patient:** _____

Address: _____ **Email:** _____

Phone:_____ **Social Security #:**_____

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 (including child)?

Name	Relationship	Age	Preferred Pronouns

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:** _____

Tied Shoes: _____ **Preferred Hand:** L / R

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

Approximately how long did you wait for this appointment?_____

How did you hear about Reach for the Top? _____

REQUEST AND AUTHORIZATION FOR TREATMENT: I authorize Reach for the Top to administer all diagnostic, treatment, and / or services recommended and 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 acknowledge that I have been informed 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 seeking, 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 been given the right to review the Notice of Privacy Practices which is also available on Reach's website and am informed that I may contact Reach at any time to obtain a current copy of the Notices of Privacy Practices.

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

_____ _____ _____

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

Initial the following statements indicating you understand our policies:

I agree to allow Reach for the Top to **send clinic correspondences, appointment reminders, and invoices to the email address** I provided above.	**(Initial)** _____
I understand that all staff are **Mandated Reporters** and are required by law to report predetermined behavior stated or witnessed to the Division for Children, Youth, and Family's (DCYF).	**(Initial)** _____
Reach encourages families to attend each session with their child to inform sessions and learn strategies to use at home. If a family leaves the session, they **must return at least 5 minutes before the end of the session**. Parents must also be readily available by phone if an emergency were to occur. Confirm the time the session ends with your therapist before you leave.	**(Initial)** _____
I understand Reach for the Top supports **graduate students** in each therapy field. I agree to allow students to observe / participate / provide services under the supervision of my child's therapist.	**(Initial)** _____
I will **not use my cell phone and / or any electronics when in the therapy clinic**, unless approved 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 Policy

Patients approved for therapy services are responsible for all charges not paid for by insurance. By signing this financial agreement, you acknowledge your understanding of this condition of service and commit to promptly paying Reach. **Patient statements when requested are sent via the email provided and the card on file will be charged on a bi-weekly basis, following the receipt of insurance remittances. A receipt will be emailed following for your records.** If you wish to pay by check, this is also available contingent upon consistent and timely payments received. If you have questions regarding your bill or charges, please contact our Office Manager.

"No Call, No Shows and Cancel without 24hr notice" impact a child's progress and staffing and will require a **fee of $40.00 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, this includes Medicaid recipients, if coverage/eligibility changes**. **(Initial)**

I give consent for Reach for the Top to appeal claims to my child's insurance company on my behalf. **(Initial)**

I understand that if for any reason I do not pay the balance for services rendered, and do not contact Reach to set up a payment plan that Reach, will charge **a late fee, $1 per day beyond the 30-day notice**, and holds the right to begin a formal collections process for money owed, with a **$90 collections fee**. **(Initial)**

My signature indicates I am the legal guardian of this patient and I understand and accept these policies.

Signature of Parent / Legal Guardian **Date**

Appointment Types

Recurring Schedule:

Therapists have a certain number of recurring spots available weekly. If your schedule aligns with an opening with a therapist trained in the areas needed, you will be placed in that recurring time slot. If your scheduling needs are going to change, let your therapist know as soon as possible and you can make that request on our website. You will be put on a schedule change list, to accommodate those needs when a spot opens; changes are made on a first-come, first-served basis.

Coverage/Make-Up Visits:

When a therapist or family is out unexpectedly a make-up visit may occur with another therapist (covering the child's needs for the therapist out, or due to available times). This is an excellent opportunity for another experienced therapist to provide a second opinion and gain additional perspective on the child's needs, performance, and strategies that may help. As well as an opportunity to see how a child responds to a 'substitute' providing helpful information in a different context.

Flexible Scheduling:

There are a few ways to get onto our flexible schedule.

a. If our therapists do not have a recurring time slot open that works for your schedule you will be on the flexible schedule until a recurring spot opens. Our team will email and/or call, as we have openings in the schedule that align with your availability. You are also able to call and check for weekly schedule openings.

b. If your attendance is inconsistent and you're unable to regularly attend a weekly spot, you will be placed on the flexible schedule.
   - **Weekly emails are sent with openings reserved on a first-respond, first-served basis.**
   - Following 4 consecutive flex appointments attended, your child will be eligible to obtain a recurring spot again once it opens.
   - If no flex spots offered are attended over an 4-week period, the child will be removed from flexible scheduling and discharged from therapy. If you were to request to return to therapy, your child would be placed on our waiting list and would require a new evaluation.

Attendance Policy

- I understand that consistent attendance of scheduled therapy sessions is critical for my child's progress.
- My schedule allows me to be compliant with my child's therapy program.
- **I must notify Reach of planned absences or vacations in advance.**
- If my child is unable to attend a therapy session**, I must notify Reach at least 24 hours before the start time**. If I do not notify Reach by phone, email, or the alert, my absence will be **considered a "no-call, no show".**
- **We charge a $40 fee for no-call, no-show appointments.**
- **We charge a $40 fee for appointments cancelled without 24 hours' notice unless it is rescheduled and attended for in-person or teletherapy services within seven days of canceling.**
- **<u>If you decline to make-up missed visits, your child will lose their weekly spot and be placed on a Flex Schedule if attendance falls</u> <u>at or below 50%</u> within a 4-week period.**
- **Patients will be automatically placed on the Flex Schedule following 1 no show.**

Thank you in advance for your understanding, cooperation, and commitment to your child's success.

My signature indicates I am the legal guardian of this patient and I understand and accept these policies.

____________________________________ ________________________

Signature of Parent / Legal Guardian **Date**

Satisfaction with Services

If you have any questions about the care your child is receiving or are unhappy with the services received in our office, please let our Director of Clinical Services or Client and Community Relations Coordinator know before leaving the clinic by calling the office at 603-740-3534. They will ensure your feedback gets to the appropriate team member and will follow up with you if they are unable to do so at the time of your visit.

Credit Card on File for Payment

Child's Name: ______________________________ **DOB:** _________________________

I, ____ (please print name) agree to **Automatic Payment.**

I understand my credit card will automatically be charged for the balance due for the above child's therapy services and/or a $40.00 fee for any 'No-call, No-Show'/'Less than 24 hours' notice cancel'; it will be paid in full bi-weekly (or the maximum weekly amount), until the balance is satisfied. We will send a receipt to the email provided below.

<u>Credit Card Information:</u>

Name as it appears on card: ____

<u>Billing Address:</u>

Street: ____

City: __________________________ **State:** _____________ **Zip Code:** ______________

Email Address (for receipts): ____

Description / Service: <u>Therapy</u> __________ **Maximum Weekly payment**____________

Cardholder Signature: ____**Date:**____________________

To safeguard this information, your card information will be encrypted in our Electronic Medical System for protection.

☐ Visa ☐ MasterCard ☐ Am/Exp **Flex Card:** ☐ Yes ☐ No

Expiration Date: ______________________________ **Security Code:** _______________________

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Credit Card Number: ____