Intake Form

General Information

Child's Name: _____ Child DOB: _____Diagnosis/Code: ___ _____
Patient Social Security# _____ Parent Social Security # _____
Parent/Guardian Name(s): _____
Address: _____ City: _____ State: _____Zip: _____
Home # _____ Cell# _____ email:_____
Emergency Contact Name/Relation: _____ Phone # _____

Referral Information

Referring Physician: _____ Phone # _____ Fax # _____
Address: _____ City: _____ State: _____ Zip: _____
Primary Care Physician: _____ Phone # _____

Insurance Information

Primary: _____Policy Holder: _____
ID Number: _____ Group Number: _____

Secondary: _____ Policy Holder: _____
ID Number: _____ Group Number: _____

Family/Social History:
Child lives with □ Biological Parent(s) □ Foster Parent □ Other: __ _____
Do you have any cultural or religious beliefs that we need to be aware of in order to provide the best possible care for your family? _____

Birth History: My Child was born □ Full Term □ Born Early? How many weeks? _____

Developmental History:
My child stayed in nursery after birth: □ No □Yes - Reason: _____
Does your child have delays in development? □ No □ Yes - Explain: _____
My child receives: □ Play Therapy □ Physical Therapy □ Occupational Therapy □ Speech Therapy
Does your Child require special assistance (nurse) or adaptive equipment (Wheelchair, braces, etc.)? □ No □ Yes – Explain:_____

Medications: _____
Allergies: _____

Are your child's immunizations up to date? □ Yes □ No – Explain: _____

List any medical conditions your child has that may require special care or precautions: _____

Past Medical History (include hospitalizations, surgeries, bone/joint, cardiac, lung/respiratory, GI, vision, hearing, neurological, etc):_____
_____
_____
_____

Parent/Guardian Signature: _____ **Date:** _____

Consent for Care

Consent for Care: I give Therapeds Works consent to evaluate and treat my child as prescribed by my child's physician and/or recommended by my therapist. I understand that I have the right to ask any questions prior to my child receiving treatment.

Other Professionals involved in child's care: I am responsible for informing Therapeds Works of any services and/or other professional involved in my child's care. For example, school therapists, cap workers, etc.

Consent for payment: I give Therapeds Works consent to bill my insurance company/provider for services rendered. As courtesy to our patients, we verify and file your insurance; however we cannot guarantee payment. I understand that I am responsible for the percentage and/or deductible not covered by my insurance company. If insurance information is not available, payment in full is due at the time of visit unless other arrangements are made by clinical director.

Co-payments: I understand that any applicable co-payments required by my insurance are paid at the time of the visit by check or money order. There is a $25.00 charge for all returned checks.

Change in insurance: I am responsible for informing Therapeds Works of any changes in my child's insurance coverage. I acknowledge I will be responsible for remaining balance not covered by insurances when a change in insurance is made.

Personal health information: I am aware that my child's information may be shared for the purpose of treatment, payment and health care operations.

Photo/video: I understand that any photos or videos of my child may be used to document my child's treatment, progress and care and for no other purpose unless I specifically grant consent.

Attendance/illness: Therapeds Works will have the option of discharging my child from further care if any of the following occur: Three consecutive missed or canceled appointments, Two no shows (i.e. missed appointments without a telephone call to cancel), or Erratic and/or inconsistent attendance (including, arriving late for appointments). **Please call to cancel if your child is sick and/or contagious. No show at appointments will be subject to a $50.00 non-refundable fee**

*** Health and safety:** I understand that Therapeds Works is responsible for reporting any abusive behavior, unsafe or unclean conditions, drug/alcohol use, and use/display of weapons.

I have read, understand and accept the above statements.

_____ _____

Parent/Guardian signature Date

Please feel free to call 254-213-2952 with any questions.

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment, or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name: _____

Parent/Guardian Signature: _____

Date: _____

HIPAA email consent

VERY IMPORTANT! PLEASE READ!

- HIPAA stands for the *Health Insurance Portability and Accountability Act*
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information
- Information stored on our computers is encrypted
- Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email
- **When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.**
- Email sent via our EMR is encrypted and considered HIPAA compliant

OPTION 1 – **ALLOW** UNENCRYPTED EMAIL
I understand the risks of unencrypted email and do hereby give permission Therapeds Works to send me personal health information via unencrypted email

_____ _____
Signature (parent or guardian if patient is a minor) **Date**

_____ _____
Printed name **Please print email address**

OPTION 2 – **DO NOT ALLOW** UNENCRYPTED EMAIL
I do not wish to receive personal health information via email

_____ _____
Signature **Date**

_____
Printed name (parent or guardian if patient is a minor)

Please bring completed form to your visit or turn in to office

PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand Therapeds Works Notice of Information Practices. I understand Therapeds Works may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that Therapeds Works will consider requests for restrictions on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Therapeds Works Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____

Patient Name

_____

Parent/Guardian Signature

_____

Date

Privacy Signature Sheet For Client

Patient Name:_____ Phone Number:_____

In the course of providing service, we create, receive, and store health information that identifies the patient. It is often necessary to use and disclose this health information in order to provide treatment, to obtain payment for our services, and to conduct health care operation involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our Notice of Privacy Practices, the use and disclosure of the patient's health information for treatment purposes not only includes care and service provided here, but also disclosures of the patient's health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of the patient's health information for purposes of payment includes:

1. Our submission of the patient's health information to a billing agent or vendor for processing claims or obtaining payment
2. Our submission of claims to third-party payers or insurers for claims review, determination of benefits, and payment
3. Our submission of the patient's health information to auditors hired by third-party payers and insurers
4. Other aspects of payment described in our Notice of Privacy Practices

When you sign this consent document, you signify that you agree and that we can and will use and disclose the patient's health information to treat them, to obtain payment for our services, and to perform healthcare operations. You also signify that you have received a copy of our Notice of Privacy Practices.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment, or healthcare operations, but as described in our Notice of Privacy Practices, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us.

I have read this document and understand it. I consent to the use and disclosure of my and my child's healthcare information for purposes of treatment, payment, and healthcare options. I acknowledge that I have received the Notice of Privacy Practices from Therapeds Works, LLC.

_____ _____

Signature Date

If you are signing as a parent/guardian/personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form.

_____ _____

Signature Date

I have read the Patient's Rights and Responsibilities and I understand it. I acknowledge that I have received the Patient's Rights and Responsibilities from Therapeds Works.

_____ _____

Signature Date

If you are signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form.

_____ _____

Signature Date

Therapeds Works, LLC Attendance Policy

Appointments must be cancelled a minimum of 24 hours in advance of your scheduled appointment start time. Canceled appointments can often be rescheduled if planned in advance. We encourage the rescheduling of missed visits in order to keep therapy consistent and to operate within your plan of care. If attendance drops below 80% within a 30 day period for any reason, you will be notified and you may lose your regularly scheduled appointment time or be discharged due to non-compliancy. Your physician will also be notified of any frequent absences or termination of therapy. An absence is considered a "No Show" anytime Therapeds Works does not receive notice of a cancellation PRIOR to the appointment start time. If we do not hear from you, or hear from you after the appointment start time has passed, the visit will be considered "No Show Status". The regular appointment time is lost after 3 No Show appointments, without exception. Cancellations without 24 hour notice and No Show appointments will be subject to a fee **of $50 per incident,** due at the time of the next visit prior to the next therapy session. As a courtesy, please give Therapeds Works as much advance notice as possible if you need to cancel. Often, those openings can be utilized to schedule therapy for other patients. Cancelations without adequate notice are a missed opportunity for both the patient to receive benefits from services and for the therapist to provide services to other individuals who may be in need.

Illness

We understand that cancellations due to illness are unavoidable. We do not allow individuals who have shown one or more of the following symptoms of contagious disease within the last 24 hours to receive treatment:

- Fever > 100 degrees (patient must be fever free without fever reducing medication over the past 24 hours)
- Open/Draining Lesion
- Vomiting/Nausea
- Lice
- Chicken Pox
- Productive Cough
- Conjunctivitis/Pink Eye
- Hand, Foot, and Mouth Disease
- Strep Throat
- Diarrhea
- Any Other Contagious Disease Not Listed

This will aid in the protection of the patient, the health of staff, other patients, and family members. Cancellations of less than 24 hours' notice due to contagious disease will not be subjected to penalty; however, please be aware that Therapeds Works may request a doctor's note before resuming therapy.

By signing this document, I certify that I have read and agree to abide by the Attendance Policy.

_____ _____

Patient/Parent/Guardian Signature Date

Therapeds Works LLC Clinic/Practice Rules/Policies

1. Parents/Guardians of infants and toddlers must stay with the child during the therapy treatment session. If the child is able to attend therapy independently, we encourage that the parent/guardian wait in the waiting area in order to reduce distractions for their child and other patients during treatment. (ABA patients, please refer to parent handbook).

2. For your child's protection and benefit, we request that parents remain on premises for the entire duration of their child's therapy treatment. Your presence is needed in case of medical emergency, for assistance with personal needs (such as toileting or feeding), or in case a therapist needs to demonstrate an intervention technique. We request that family members/caregivers remain in the building during treatment when accompanying adult patients who are unable to independently address their own medical or personal needs.

If you must leave the building during your child's therapy for any reason, please tell the office and your therapist before you leave, provide a contact number, and return at least 10 mins before the end of the therapy session.

3. Parents/family members must remain in the designated waiting area during the patient's therapy appointments. Please do not interrupt treatment sessions or go to the treatment rooms/gym area unless accompanied by staff.

4. Please do not come directly to the treatment areas when you arrive at the clinic, even if you are late. Notify Therapeds Works staff of your arrival and the therapist will come to the waiting room to get you.

5. For the privacy and HIPAA protection of all patients, please DO NOT video record, audio record, or take photographs on Therapeds Works property without first obtaining permission from the director.

6. Do NOT smoke while on Therapeds Works property or present with smoke filled clothing/hair/skin, etc. Due to the medical sensitivities of patients, we cannot have first, second or third hand smoke in our clinic, as this can medically compromise other patients.

7. Please arrive at least 5 minutes Prior to your scheduled treatment session with the exception of Evaluations, please arrive 15 minutes early unless your intake packet is submitted prior to the date of the evaluation. If you are not in clinic at the time of your scheduled appointment, staff will call and/or text to check on you, as we must document reason for tardiness or no show in your EMR record.

8. Please let us know of any allergies you or your family members may have so that we can take extra caution to protect you and your family.
We sincerely appreciate your commitment to therapy! It is our desire to work together with family members to create an environment that is most conducive to treatment success. These rules are in place to protect the safety and privacy of our patients and to eliminate distractions that impede successful treatment. Thank you so much for your understanding and cooperation!

I have read and agree to abide by the Therapeds Works Clinic Rules/Policies.

_____ _____

Patient/Parent/Guardian Signature Date