Therapy Accomplished

Intake Form

Personal Information

Patient's Name: ____________________________________ DOB: __________________________

Patient's Social Security Number: ____ Sex: M F

Parent/ Guardian Name(s): ____

Relationship to Patient: _________________________ Guardian DOB: _________________________

Guardian's Social Security Number: ____

Home Phone #: ________________________________ Cell Phone #: ___________________________

Work Phone #: ________________________________ Other Phone #: __________________________

Preferred Contact #: ☐Cell ☐Home ☐Work If cell, would you like texts? ☐Yes ☐No

Home Address: ____

City, State, ZIP: ____

Physician's Name and Phone #: ____

In Case of Emergency:
Name of local friend or relative (not living at same address): ______________________________

Relationship to Patient: _________________________ Phone #: _______________________________

How did you hear about our therapy services? ____

Medical History

List current concerns and reason for coming to therapy:

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List past medical history:

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List all medications and reason taking:

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List past surgeries or hospitalizations and age of occurrence:

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Allergies: ____

History of Seizures: ____

Has your child had therapy in the past? ☐PT ☐OT ☐Speech Where? ___________________

Current school: ______________________________________ Grade: _______________________

Is there anything you wish to discuss about behavior or emotions? If so, please explain:

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Is there anything else you wish to add? ____

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____

Goals for therapy: ____

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Insurance Liability Form

Insurance Information

Patient Name: ______________________________________ DOB: ____________________

Insurance Name: ____

Policyholder Name (person who has insurance policy): _________________________________

Policyholder's Address (if different than above): _____________________________________

City, State, ZIP: ____

Policyholder's Phone # (if different than above): _____________________________________

Policyholder's Employer: ______________________________ Insured's DOB: _____________

Policy/ ID Number: ____________________________ Group Number: __________________

Effective Date: _________________________ Termination Date: ________________________

Claims Address: ____

Insurance Co. Customer Service Phone #: ____

Insurance Co. Prior Authorization Phone #: ____

Type of Plan (please circle): PPO HMO EPO HAS POS FFS Indemnity Other

Authorization to Bill Insurance

I authorize the release of any information necessary to file a claim to my insurance company. I authorize payment of benefits to Therapy Accomplished, LLC. If sent to me, I will give copies of Explanation of Benefits and payments received from my insurance company to Therapy Accomplished, LLC.

_______________________________________ _______________

Policyholder's Signature **Date**

Therapy Accomplished

Parent/ Guardian Authorization

I ________________________________ (parent/guardian name) certify that I am a parent or legal guardian of ________________________________ (patient's name) and give Therapy Accomplished, LLC permission to provide therapies for my child. I authorize Therapy Accomplished, LLC to:

- Provide Evaluations, Progress Reports, and other required documentation to your child's primary care physician/ referring healthcare provider in order to obtain prescriptions to provide therapy services and coordinate care.
- Provide Evaluations, Progress Reports, and other required documentation to your insurance company and/or your Support Coordinator as is required for payment of services.
- Collaborate verbally and in writing with other healthcare professionals, therapy and childcare providers involved in my child's care in order to ensure integrated service delivery.
- Bill my insurance company and other payment sources for services provided.

I agree to forward to Therapy Accomplished, LLC any payments received from insurance companies for services provided. I have received a copy of this Parent/ Guardian Authorization for my records.

____ ____________________

Signature of Parent/ Guardian Date

____

Parent/ Guardian Name Printed

Therapy Accomplished

Patient Cancellation and No-Show Policy

Consistent attendance of all therapy sessions is very important for your child's progression. No shows and frequent cancellations are highly discouraged.

Please contact your therapist at (928) 279-3652 if your child is unable to attend his/her regularly scheduled therapy appointment. **Cancelled appointment notifications must be made 24 hours in advance or before 7:30am on the day of the scheduled appointment, with the exception of emergencies and unforeseen illnesses.** Due to our community being rural, rescheduling an appointment for the same week may not be possible, as the therapist travels all over our county. *For DDD Patients*: Your support coordinator will be notified of any no shows, and frequent cancellations. DDD requires a parent/guardian be present and actively participate during therapy sessions.

The following definitions and procedures apply to all attendance topics.

- **No Shows:**
  - *Definition:* A no show is any missed appointment without a phone call to cancel the appointment(s) by **7:30am** on the day of the scheduled appointment. If your therapist arrives at your home and no one answers the door, or if the therapist is notified after she arrives that your child cannot be seen for any reason, this is considered a no show.
  - *Procedure:* After three (3) no show appointments, your child will be taken off of the therapy schedule, and discharged from services.
- **Cancellations:**
  - *Definition:* A cancellation is any appointment cancelled by phone or in person **24 hours in advance** of the scheduled appointment.
  - *Procedure:* If your child's attendance rate falls below 75%, there is a possibility that your child's therapy time may be offered to another child on our waiting list. Families who are planning to be absent for greater than 2 weeks will be removed from their treatment time, unless previously arranged with your therapist.

Thank you for your cooperation in helping us to provide the best possible outcomes for your child.

Patient/Child's Name: ____

Parent/Guardian's Signature: ____________________________________ Date: ____________