ADVANCED THERAPY SOLUTIONS

EXCEEDING EXPECTATIONS...

OFFICE INTAKE

A.T.S. must have this page filled out completely by a parent or legal guardian BEFORE any Evaluation can be initiated.

PATIENT'S NAME : _____ **DATE OF BIRTH :** _____ **SS #:** _____

PARENT OR GUARDIAN'S NAME: _____

PRIMARY PHYSICIAN OR GROUP :_____

PRIMARY INSURANCE COMPANY: _____

PRIMARY INSURED'S NAME _____ **DATE OF BIRTH :** _____ **SS #:** _____

SECONDARY INSURANCE COMPANY: _____

SECONDARY INSURED'S NAME : _____ **DATE OF BIRTH :** _____ **SS #:** _____

IF INSURANCE IS TRICARE: STANDARD or PRIME (please circle one)

DOES THIS PATIENT HAVE INSURANCE THROUGH ANOTHER PARENT OR GUARDIAN? YES or NO (circle one)
IF YES, INSURANCE COMPANY NAME IS _____

PRIMARY INSURED'S NAME IS_____**DATE OF BIRTH :** _____ **SS #:** _____

DOES THIS PATIENT HAVE THEIR OWN INSURANCE (example TennCare) ? YES or NO (circle one)
IF YES, INSURANCE COMPANY NAME IS _____

PRIMARY INSURED'S NAME IS_____**DATE OF BIRTH :** _____ **SS #:** _____

DID YOU CALL YOUR INSURANCE COMPANY TO SEE IF THE SERVICES PROVIDED HERE ARE COVERED FOR THE PATIENT?
YES or NO (circle one)

FAILURE TO PROVIDE ALL INSURANCE INFORMATION WILL RESULT IN THE PARENT/GUARDIAN BEING RESPONSIBLE FOR ALL FEES ASSOCIATED WITH EVALUATIONS AND THERAPIES. (to show that you have read the following two statements, write your initials in the blank to the left)

_____ **I UNDERSTAND I AM RESPONSIBLE FOR ANY BALANCE THE INSURANCE COMPANIES DO NOT PAY**

_____ **I WILL INFORM A.T.S. OF ANY CHANGES TO INSURANCE POLICIES, ADDITIONAL INSURANCE OR LOSS OF INSURANCE COVERAGE AS SOON AS CHANGES ARE MADE**

PATIENT OR PATIENT'S PARENT OR GUARDIAN MUST PROVIDE ATS OFFICE WITH THE FOLLOWING:

- ☐ ***COPY OF DRIVER'S LICENSE***
- ☐ ***COPY OF INSURANCE CARD(s) (OR MILITARY ID)***

ADVANCED THERAPY SOLUTIONS

EXCEEDING EXPECTATIONS...

Consent for Services

I, the undersigned, authorize Advanced Therapy Solutions, LLC to provide ABA Therapy, Behavioral Health, Occupational Therapy, Physical Therapy, Speech Therapy & Feeding Therapy services for me/my child. I also consent for the release of all medical, ABA, Behavioral Health, Occupational Therapy, Physical Therapy, Speech Therapy & Feeding Therapy information for the purposes of medical treatment, payment, and for regulatory agencies.

Printed name of client

Date

Signature of client or legal guardian

Relationship to client

ADVANCED THERAPY SOLUTIONS

EXCEEDING EXPECTATIONS...

Authorization to Release Medical Information

I, the patient, parent, or legal guardian, authorize the release of information for the purpose of medical treatment, payment, for regulatory agencies, and care coordination for:

First MI Last Date

Street Address City State Zip

Releasing Agent	Receiving Agent
Organization	Advanced Therapy Solutions, LLC
Address	Address
City State Zip	City State Zip
Phone Fax	Phone Fax

Advanced Therapy Solutions may release the following medical information:

All ☐ History and Physical☐ Demographic Information☐
Evaluations☐ Test results☐ Behavioral Health Information☐
Therapeutic office notes☐ Discharge Summary☐ Verbal☐

Print name Date

Sign name Date

The therapists at Advanced Therapy Solutions LLC consult with parents in the waiting room & other open areas. If you are uncomfortable with this, we can arrange something different for you, but please notify staff in the front office as soon as possible.

Authorization may be revoked at any time per the discretion of the patient, parent or legal guardian of the above aforementioned by signing below:

Signature Date

ADVANCED THERAPY SOLUTIONS

EXCEEDING EXPECTATIONS...

Financial Policy

Thank you for choosing Advanced Therapy Solutions as your Speech, Occupational & Physical Therapy provider. We are committed to providing the best possible treatment for our patients. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require all patients or legally responsible individuals to read and sign prior to evaluation or treatment. All patients must also complete our Office Intake Information and Insurance Form before being evaluated or treated.

It is a courtesy of our office staff to file claims for our patients, but an insurance policy is a contract between the patient and the insurance company. We cannot guarantee payment of your claims. Reduction or rejection of insurance claims does not relieve your financial obligation.

Adult patients are responsible for full payment of service.

The adult accompanying a minor and/or the parents (or guardians of the minor) are responsible for payment at the time of service if required.

All co-pays, deductibles and co-insurances are due at the time of service.

Our office accepts: VISA, MASTERCARD, DISCOVER, CASH & DEBIT CARDS

I acknowledge responsibility for payment for all medical fees regardless of any insurance I may have to assist me in this responsibility. I assign all medical benefits payable to Advanced Therapy Solutions. I understand that I am responsible for full payment, unless I am under the coordination and care of services through Tennessee's Early Intervention System (TEIS), for all non-covered charges. If my insurance carrier does not pay the charges submitted by Advanced Therapy Solutions in a timely manner (within 90 days), I understand that I am responsible for full payment. Should I become delinquent on these bills, I give permission for information to be released to the appropriate credit reporting agencies. In the event that charges incurred are not paid in full when due and collection activity is instituted, whether by a collection agency or an attorney (or both), I will be responsible for all costs including, but not limited to, collection fees, attorney's fees, skip tracing costs and court costs. The amount I owe will not be less than 35% of total costs.

I have read, understand and agree to the above Financial Policy.

_____ _____

Patient or Responsible Party Date

_____ _____

Co-Responsible Party Date

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

ADVANCED THERAPY SOLUTIONS

EXCEEDING EXPECTATIONS...

HEALTH AND ILLNESS POLICY

Advanced Therapy Solutions follows the Health Department's guidelines for the childcare program setting. A child is not to be brought to therapy if any of the following symptoms are observed in the past 24 hours.

*Fever and sore throat, rash, vomiting, diarrhea, earache, irritability, or confusion. Fever is defined as having a temperature of 100 degrees or higher taken under the arm, 101 degrees if taken orally, or 102 degrees if taken rectally.

*Diarrhea with runny, watery, or bloody stools.
*Vomiting two or more times in a 24 hour period.
*Body rash or bumps with fever.
*Sore throat with fever and swollen glands
*Severe coughing with redness or blue in the face or makes high-pitched whooping sound after coughing
*Eye discharge-where thick mucus or pus is draining from the eye, or pine eye, conjunctivitis (yellowish discharge from eyes)
*Yellowish skin or eyes
*Lice, scabies, or other parasitic infestation
*Difficult or rapid breathing
*Stiff neck
*Ring worms
*Discoloration of nasal drainage
*Irritable, continuously crying, or requires more attention than the therapist can provide.

In order to ensure the health and welfare of all the children at our facilities and to decrease the amount of illnesses, **YOUR CHILD SHOULD HAVE A NORMAL TEMPERATURE OF 98.6 FOR 24 HOURS BEFORE HE/SHE COMES TO THERAPY.**

The therapist has the option to refuse services to a sick child.

Thank you for your cooperation. Our goal is to help your children and keep them healthy and safe.

ADVANCED THERAPY SOLUTIONS

EXCEEDING EXPECTATIONS...

ATTENDANCE POLICY

CANCELLATIONS:

- If you must cancel an appointment for a reason other than sudden illness, you must contact our office or let your therapist know 24 hours before your scheduled appointment

- If you are to cancel three scheduled therapy sessions for non-medical emergencies without giving adequate prior notification to your therapist, it will be at the discretion of Advanced Therapy Solutions whether or not to terminate services.

NO SHOWS:

- Failure to cancel or to appear during an appointment time is considered a "no show". A $15 fee will be assessed. Please contact our office immediately to discuss future appointments.

- If three (no shows(occur, the patient's appointment time will be

  automatically offered to another patient waiting for services.

A NOTE FROM THE THERAPIST:

We expect for you to make every effort possible to attend your scheduled appointments. When we establish a plan of care for the patient, we base our goals on the patient having consistency. If the patient misses appointments, they will not meet their goals as quickly, and will have to be enrolled in therapy for a longer period of time. The success of our treatment sessions depends on consistency. In the event that you do have to cancel, we strongly encourage you to reschedule, even if it is with another therapist. We actually enjoy when another therapist sees one of our patients because it gives us another opinion of ideas for the patient. We are always in close communication with each other. Any other concerns you may have, please discuss this with your therapist.

I have read and understand the attendance policy of Advanced Therapy Solutions:

Signature_____ Date_____

ADVANCED THERAPY SOLUTIONS

EXCEEDING EXPECTATIONS...

Notice of Privacy and Security Practices: Acknowledgement of Receipt

I, the undersigned, acknowledge that I understand Advanced Therapy Solutions Notice of Privacy & Security Practices. Our Notice of Privacy & Security Practices provides you with information about how we may use or disclose your protected health information (PHI). The Notice also explains how you can access, amend, and restrict your protected health information. We encourage you to read it in full. **It is available for you to read in full upon request or on our website (advancedtherapy.net).**

Printed name of client

Date

Signature of client or legal guardian

Relationship to client

ADVANCED THERAPY SOLUTIONS

EXCEEDING EXPECTATIONS…

Pediatric Physical Therapy Evaluation CASE HISTORY

CHILD'S NAME: _____D.O.B.: _____ SEX: _____ AGE: _____

ADDRESS: _____CITY/STATE/ZIP: _____

PHONE: HOME:_____ WORK: _____ OTHER: _____

Email: _____

IN CASE OF EMERGENCY, CONTACT:

Name:_____ Relationship:_____ Phone#:_____

Alternate Phone#: _____ Work Place: _____

FAMILY INFORMATION:

FATHER/GUARDIAN Name _____ Age ____ Occupation_____

MOTHER/GUARDIAN _____ Age ____ Occupation_____

SIBLINGS: (NAMES/AGES) _____

With whom does the child spend most of his or her time? _____

Does your child attend school/daycare? Where? How often?

REFERRAL:

WHO REFERRED YOU FOR THIS EVALUATION (PEDIATRICIAN (doctor's name)/GROUP)?

BACKGROUND INFORMATION:

Describe your primary concern(s) regarding your child? _____

At what age did you first become concerned? _____

Are there any other family members with a history of developmental concerns? (e.g. mental deficits, learning deficits, cerebral palsy) _____

Parent, legal guardian, or authorized person must bring child to the office for therapy , unless otherwise notified by therapist.

Parent. Signature _____ Date _____

ADVANCED THERAPY SOLUTIONS

EXCEEDING EXPECTATIONS…

PREGNANCY, BIRTH AND HEALTH:

DURATION OF PREGNANCY (in weeks) _____ WAS PRENATAL CARE RECEIVED (CIRCLE ONE): YES NO

Pregnancy Proceeded: ☐ Without Complications ☐ With Complications (Please explain below)

Complications during Pregnancy (if any):

☐ Multiple Births ☐ Eclampsia ☐ Pre-Eclampsia ☐ Polyhydramnios ☐ Positive for CMV

☐ Premature Labor ☐ Substance Exposure ☐ Positive for Herpes ☐ Positive for HIV

Other: _____

_____

BIRTH:

Birth Weight: _____ Delivery Proceeded: ☐ Without Complications ☐ With Complications (Please explain): _____

The delivery was: ☐ Normal ☐ Caesarian ☐ Emergency Caesarian ☐ Forceps

☐ Breech ☐ Vacuum-Assisted

Length of Child's Hospital Stay: _____ Did your child transfer hospitals? (CIRCLE ONE): YES NO

Were any of the following conditions evident at birth: ***check mark all that apply:***

☐ Jaundice ☐ Drug Addiction ☐ Intensive care ☐ Anoxia(blue)

☐ Feeding Difficulties ☐ Special Monitoring ☐ Other (please explain)

Other: _____

_____

HEALTH:

Since birth, has your child been in good general health? ____ If not, please explain: _____

_____

Does your child have any allergies? _____

What are your child's likes?

_____

What are your child's dislikes?

_____

ADVANCED THERAPY SOLUTIONS

EXCEEDING EXPECTATIONS…

HEALTH continued:

What are your goals/expectations for PT (**PLEASE PROVIDE AN ANSWER TO THIS QUESTION)**?

_____

Complications following birth: ☐ Club Foot ☐ Cytomegalovirus (CMV) ☐ Failure to thrive

☐ IVH Bleed; Grade (I-IV): _____ ☐ Patent Ductus Arteriosis (PDA) ☐ Respiratory Syncytial Virus (RSV)

☐ Retinopathy of Prematurity (ROP) ☐ Oxygen Dependency ☐ VP Shunt ☐ Reflux

☐ Seizures ☐ Pneumonia ☐ Broken Bones ☐ Asthma ☐ Periventricular Leukomalacia (PVL)

Other: _____

Diagnosed/Suspected Syndromes or medical conditions (e.g. cerebral palsy, autism, genetic syndromes, muscular dystrophies, brain injuries, etc): _____

_____

Please list all surgeries/hospitalizations occurring after birth with approximate dates: _____

_____

Please list ALL CURRENT medications (including vitamins, herbs, OTC): _____

Please list all known allergies (e.g. medications, latex, foods, etc): _____

Please list any diagnostic tests or imaging studies that have been conducted:

TEST	WHEN/WHERE?	DETAILS/RESULTS
Bloodwork/ Lab Tests		
Bone Density Scan		
CT Scan		

EEG		
EMG		
MRI		
Swallow Study		
Ultrasound		
X-Ray		
Other: _____		
Other: _____		

ADVANCED THERAPY SOLUTIONS

EXCEEDING EXPECTATIONS…

Please list all of your child's current physicians:

NAME	SPECIALTY	REASON	DATE OF LAST VISIT

Has your child had previous physical therapy? (CIRCLE ONE) YES NO

If yes, for how long? _____ What were they treated for? _____

Does your have any of the following medical or therapy equipment?

☐ Assistive Device for walking (e.g. walker, gait trainer, cane, crutches, etc) ☐ Stander

☐ Orthotics (e.g. AFOs/SMOs/foot inserts, etc) ☐ Wheelchair/Stroller

Other (please list other medical equipment below not specified above: _____

_____

Is there a diagnosed hearing loss? Yes/No please explain.

Is there a vision problem? Yes/No please explain.

Present Level of Activity (give approximate age for the following)

Sat Alone:	Crawling:	Walking:
Running:	First Words:	Rolling :
Jumping:	Standing:	Hold head up:
Stairs		