

# 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)

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## 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

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## 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		
_____ Organization		
_____ Address		
_____ City	_____ State	_____ Zip
_____ Phone	_____ Fax	

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

### Advanced Therapy Solutions may release the following medical information:

- |   |   |  |
|---|---|--|
| All <input type="checkbox"/>                      | History and Physical <input type="checkbox"/> | Demographic Information <input type="checkbox"/>       |
| Evaluations <input type="checkbox"/>              | Test results <input type="checkbox"/>         | Behavioral Health Information <input type="checkbox"/> |
| Therapeutic office notes <input type="checkbox"/> | Discharge Summary <input type="checkbox"/>    | Verbal <input type="checkbox"/>                        |

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

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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.

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Patient or Responsible Party      Date

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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

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## 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](http://advancedtherapy.net)).**

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Printed name of client

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Date

---

Signature of client or legal guardian

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Relationship to client

# ADVANCED THERAPY SOLUTIONS

EXCEEDING EXPECTATIONS...

## Pediatric Speech Therapy Evaluation CASE HISTORY

CHILD'S NAME: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ SEX: \_\_\_\_\_ AGE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/STATE/ZIP: \_\_\_\_\_

HOME PH: \_\_\_\_\_ WORK PH: \_\_\_\_\_ 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 (doctor's name/Group)? \_\_\_\_\_

Is your child receiving other therapy evaluations at Advanced Therapy Solutions? (CIRCLE ALL THAT APPLY)

Physical therapy   Occupational therapy   Speech therapy   Feeding therapy   Behavioral therapy

### **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...*

## PLEASE PROVIDE AN ANSWER TO THE FOLLOWING QUESTIONS:

1. Is there anything your child is not doing that you think they should be doing? **YES NO**

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2. Is there anything your child is doing that you are concerned about? **YES NO**

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3. Is there anything your child used to be able to do but is no longer doing? **YES NO**

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4. Is there anything other children your child's age can do that is difficult for your child? **YES NO**

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## 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 you child transfer hospitals? (CIRCLE ONE ): **YES NO**

# ADVANCED THERAPY SOLUTIONS

EXCEEDING EXPECTATIONS...

**BIRTH (CONTINUED):** 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):

**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? \_\_\_\_\_

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

IVH Bleed; Grade (I-IV): \_\_\_\_     Patent Ductus Arteriosus (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):

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): \_\_\_\_\_

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

# ADVANCED THERAPY SOLUTIONS

*EXCEEDING EXPECTATIONS...*

TEST	WHEN / WHERE ?	DETAILS / RESULTS
Bloodwork / Lab tests		
Bone Density Scan		
CT Scan		
EEG		
EMG		
MRI		
Swallow Study		
Ultrasound		
X-Ray		
Other:		
Other:		

Please list all of you 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 child currently use any of the following medical or therapy equipment?

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

Orthotics (e.g. AFOs/SMOs/foot inserts)       Wheelchair

**Hearing Test (check one):**     Never Tested; No Concerns       Never Tested; Have Concerns

Normal Test Results       Abnormal Test Results \_\_\_\_\_

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**Vision Test (check one):**  Never Tested; No Concerns  Never Tested; Have Concerns

Normal Test Results  Abnormal Test Results \_\_\_\_\_

**Milestone:** (give approximate age for the following)

Sat Alone: \_\_\_\_\_ Crawling: \_\_\_\_\_ Walking: \_\_\_\_\_

Running: \_\_\_\_\_ First Words: \_\_\_\_\_ Rolling: \_\_\_\_\_

Jumping: \_\_\_\_\_ Standing: \_\_\_\_\_ Hold Head Up: \_\_\_\_\_

Stairs: \_\_\_\_\_

**Home Environment:** With whom does the child live? \_\_\_\_\_

Are there stairs to get in the child's home? **YES NO** If yes, How many? \_\_\_\_\_

Are there stairs inside the home? **YES NO** If yes, How many? \_\_\_\_\_

Does the child fall often at home? **YES NO** If yes How many times a day (average)? \_\_\_\_\_