Adult Confidential Intake Data

Availability for Scheduling:

Patient Information

First Name: _____ **Middle Name:** _____

Last Name: _____ **Nickname:** _____

Sex: _____ **Gender:** _____

Birthdate: _____ **SSN:** _____

Race: _____ **Marital Status:** _____

Referred By: _____ **Work Accident:** _____

Auto Related: _____ **Other Accident:** _____

Accident Date: _____ **Occupation / School Status:** _____

Prounouns: _____

Contacts

Contact #1

Full Name: _____ **Address:** _____

City: _____ **State:** _____

Zip Code: _____ **Email:** _____

Phone #: _____ **Phone Note:** _____

Cell #: _____ **Cell Note|Relationship to Patient & Phone Carrier:** _____

Emergency #: _____ **Emergency Note|Relationship to Patient:** _____

Email Appointment Reminders: _____

Contact #2

Full Name: _____ **Address:** _____

City: _____ **State:** _____

Zip Code: _____ **Email:** _____

Phone #: _____ **Phone Note:** _____

Cell #: _____ **Cell Note|Relationship to Patient & Phone Carrier:** _____

Emergency #: _____ **Emergency Note|Relationship to Patient:** _____

Email Appointment Reminders: _____

Pronouns: _____ **Employer:** _____

What is your preferred method of contact?: _____

Alternate Contact

Full Name: _____ **Address:** _____

City: _____ **State:** _____

Zip Code: _____ **Email:** _____

Phone #: _____ **Phone Note:** _____

Cell #: _____ **Cell Note|Relationship to Patient & Phone Carrier:** _____

Emergency #: _____ **Emergency Note|Relationship to Patient:** _____

Email Appointment Reminders: _____

Pronouns: _____ **Employer:** _____

What is your preferred method of contact?: _____

Primary Care Doctor

Name: _____ **Phone #:** _____

Fax #: _____ **Medical Diagnosis (if known):** _____

Primary Insurance

Insurance #1

Insurance Company: _____ **Insured ID:** _____

Group Name: _____ **Group Number:** _____

Guarantor's Relationship to Patient: _____ **Guarantor's First Name:** _____

Guarantor's Last Name: _____ **Guarantor's SSN (If Military):** _____

Guarantor's Sex: _____ **Guarantor's Birthdate:** _____

Guarantor's Address: _____ **Guarantor's City:** _____

Guarantor's State: _____ **Guarantor's Zip:** _____

Guarantor's Phone: _____ **Guarantor's Organization:** _____

Insurance Effective From: _____ **Insurance Effective To:** _____

Remaining Deductible: _____ **Total Deductible:** _____

Remaining Out of Pocket: _____ **Total Out of Pocket:** _____

Remaining Monetary Max: _____ **Total Monetary Max:** _____

Co-Pay: _____ **Percent Insured:** _____

Yearly Visits: _____

Insurance #2

Insurance Company: _____ **Insured ID:** _____

Group Name: _____ **Group Number:** _____

Guarantor's Relationship to Patient: _____ **Guarantor's First Name:** _____

Guarantor's Last Name: _____ **Guarantor's SSN (If Military):** _____

Guarantor's Sex: _____ **Guarantor's Birthdate:** _____

Guarantor's Address: _____ **Guarantor's City:** _____

Guarantor's State: _____ **Guarantor's Zip:** _____

Guarantor's Phone: _____ **Guarantor's Organization:** _____

Insurance Effective From: _____ **Insurance Effective To:** _____

Remaining Deductible: _____ **Total Deductible:** _____

Remaining Out of Pocket: _____ **Total Out of Pocket:** _____

Remaining Monetary Max: _____ **Total Monetary Max:** _____

Co-Pay: _____ **Percent Insured:** _____

Yearly Visits: _____

Insurance #3

Insurance Company: _____ **Insured ID:** _____

Group Name: _____ **Group Number:** _____

Guarantor's Relationship to Patient: _____ **Guarantor's First Name:** _____

Guarantor's Last Name: _____ **Guarantor's SSN (If Military):** _____

Guarantor's Sex: _____ **Guarantor's Birthdate:** _____

Guarantor's Address: _____ **Guarantor's City:** _____

Guarantor's State: _____ **Guarantor's Zip:** _____

Guarantor's Phone: _____ **Guarantor's Organization:** _____

Insurance Effective From: _____ **Insurance Effective To:** _____

Remaining Deductible: _____ **Total Deductible:** _____

Remaining Out of Pocket: _____ **Total Out of Pocket:** _____

Remaining Monetary Max: _____ **Total Monetary Max:** _____

Co-Pay: _____ **Percent Insured:** _____

Yearly Visits: _____

DoD Benefits Number (If Military): _____

Secondary Insurance

Insurance Company: _____ **Insured ID:** _____

Group Name: _____ **Group Number:** _____

Guarantor's Relationship to Patient: _____ **Guarantor's First Name:** _____

Guarantor's Last Name: _____ **Guarantor's SSN (If Military):** _____

Guarantor's Sex: _____ **Guarantor's Birthdate:** _____

Guarantor's Address: _____ **Guarantor's City:** _____

Guarantor's State: _____ **Guarantor's Zip:** _____

Guarantor's Phone: _____ **Guarantor's Organization:** _____

Insurance Effective From: _____ **Insurance Effective To:** _____

Remaining Deductible: _____ **Total Deductible:** _____

Remaining Out of Pocket: _____ **Total Out of Pocket:** _____

Remaining Monetary Max: _____ **Total Monetary Max:** _____

Co-pay: _____ **Percent Insured:** _____

Yearly Visits: _____

DoD Benefits Number (If Military: _____

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign and authorize payment directly to Life Span Occupational Therapy LLC, medical insurance benefits otherwise payable to me in an amount not to exceed the charges for its services. I understand that it is my responsibility to inform Life Span of any changes to my insurance and also understand that I am financially responsible to Life Span for any charges not paid under this assignment and agree to pay such charges.

Signature: _____ **Date:** _____
Date: _____

Patient Rights & Policies

Federal regulations require that health care providers like Life Span Occupational Therapy describe for clients the circumstances in which therapy and medical information may be used and disclosed, and how you can access this information.
Initial Each Section Below:

Treatment: For treatment purposes, personal health information about you may be released to therapists, doctors, nurses, technicians, caseworkers and/or other individuals who are involved in the provision of your care.

Initial: _____
Date: _____

Billing: For services we have rendered, your therapist may use and disclose information to obtain payment from your health plan or any other party financially responsible for your care. We may also disclose information to your health plan to obtain prior approval or to determine whether your plan will cover the cost of services. Your insurance is billed as a courtesy to you, it's your responsibility to know your policy coverage for the services you seek, responsibilities for copays, co-insurance, deductibles, in and out of network responsibilities and uncovered services. Any outstanding payments will be billed to you directly via a third-party billing agency: **Freedom Billing**. You may pay by check or credit card at the time of service or choose to be invoiced monthly. We do not balance bill; you will only be billed for your responsibility for copays, deductibles, coinsurance or services not covered by insurance.

Initial: _____
Date: _____

Required By Law: We may use and disclose health information when required to do so by federal, state, or local law. We are required to disclose information to appropriate government authorities if we suspect a patient has been the victim of abuse, neglect or domestic violence.

Initial: _____
Date: _____

Patient Rights: You have the following rights regarding Protected Health Information. You can exercise these rights by presenting a written request to our Privacy Officer.

- You have the right to review or obtain a copy of your health information. Usually this includes medical and billing information. We may charge you a reasonable cost-based fee for copying and mailing the information, allow 10 working days for processing.
- You have the right to request an amendment to your health information if you believe it is incorrect or incomplete.
- You have the right to obtain an accounting of all persons to which we have disclosed information for purposes other than those listed above. This request must state a time period, which may not be longer than six years. A reasonable fee may be assessed for our time in accessing this information.
- You have the right to request that we communicate with you in an alternative way or at an alternative location.
- You have the right to a copy of our Privacy Practices.

Initial: _____
Date: _____

Cancellations/No Shows: Please give 24 hours' notice to cancel a scheduled appointment, please attempt to reschedule appointments to ensure continuity of care. Late cancellations or non-shows will be charged a $70 fee (Medicaid except). If you no show more than 3 consecutive appointments or do not keep up a 80% attendance rate the therapist has the right to put the client back on the waiting list until a new appointment time is available starting 8/1/2022.

Initial: _____
Date: _____

Private Pay Rates: Billed at $350 for any evaluation/assessment visits, $130 per hour of treatment. Services not covered by insurance will be billed at private pay rates. The following services are not covered by insurance:

- Letters for equipment, layers, education
- Attending meetings, i.e., court, IEP's lawyer meetings
- Parent or caregiver training outside of treatment session with the insured patient
- Group sessions

Initial: _____
Date: _____

Home Programs: Your insurance company expects that you are actively participating in your prescribed home programs. Patients not actively participating run the risk of the insurance denying coverage rendering you responsible for payment.

Initial: _____
Date: _____

Travel: Home visits over 30 minutes away from the clinic will be billed an additional mileage based on IRS rates and negotiated with the client starting 2/1/2017.

Initial: _____
Date: _____

Changes to this Notice: We reserve the right to change our privacy practices and the terms of this Notice at any time. We will make revised copies of this Notice available to you upon request.

Initial: _____
Date: _____

I hereby give Life Span Occupational Therapy permission to treat me and to be notified by email, phone or text about my appointments. This notice and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. By my signature I acknowledge receipt of this Notice of Privacy Practices Statement for the patient listed below.

Full Name: _____ **Signature:** _____
Date: _____

Date: _____