Child and Adolescent Confidential Intake Data

Availability for Scheduling:

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Patient Information

First Name: ____________________

Middle Name: ____________________

Last Name: ____________________

Nickname: ____________________

Sex: ____________________

Gender: ____________________

Birthdate: ____________________

SSN: ____________________

Race: ____________________

Marital Status: ____________________

Referred By: ____________________

Occupation Organization / School: ____________________

School Grade: ____________________

Pronouns: ____________________

Primary Contact

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 of Parent or Legal Guardian: ____________________

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 your child may be released to therapists, teachers, doctors, nurses, technicians, school district personnel, caseworkers and/or other individuals who are involved in the provision of your child's care with a signed release of information form.

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 child's 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. <u>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.</u> 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, balances need to be paid by the due date to ensure continuation of services. 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 child's 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 clinic days for processing.
- You have the right to request an amendment to your child's 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 no-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 8/1/22.

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 my child. This notice and any alterations or amendments made herein 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 child listed.

Child's Name: ______________________

Signature of Parent or Legal Guardian: ______________________

Date: ______________________

Date: ______________________