**Life Span Occupational Therapy**
**Confidential Intake Data**

**Date**

**NAME**: (First) (Middle Initial) (Last)

**DATE OF BIRTH** **SEX** (check) F ☐ M ☐

Employer

**ADDRESS** Apt.

(Street)

City State Zip

Home #: Cell #: Work #: E-mail:

Alternate Contact Name Phone:

Relationship to patient

**Who is the primary or best contact for the patient regarding their appointments?*

**PRIMARY CARE DOCTOR**: Phone:

Diagnosis (if known)

**PRIMARY INSURANCE COMPANY** **Provide a copy of your insurance card**

**Subscriber's Name and Date of Birth**

**SECONDARY INSURANCE COMPANY** **Provide a copy of your insurance card**

**IF MILITARY PLEASE PROVIDE SS# OF SUBSCRIBER**

**MEDICAID/DSHS** (check) Y ☐ N ☐ **If yes, please show your card, inform therapist if provider changes**

**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

# Patient Rights

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 in box**

☐ **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.

☐ **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.

☐ **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.

☐ **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.
- 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 and may not include dates before April 14, 2003. 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.

☐ **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 $20 fee (Medicaid except). If you no show more than 3 consecutive appointments or do not keep up a 60% attendance rate the therapist has the right to put the client back on the waiting list until a new appointment time is available starting 2/1/17.

☐ **Home Programs:** Your insurance company expects that you are activity participating in you prescribed home programs. Patients not activity participating run the risk of the insurance denning coverage.

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

**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.

I ☐ hereby give Life Span Occupational Therapy permission to treat.

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.

Name ☐ Signature ☐ Date ☐

**Life Span Occupational Therapy**

# RELEASE OF INFORMATION

I, (Caregiver/ patient) _____ , hereby grant consent to _____, occupational therapist, to give and/or receive information pertaining to DME, and therapy/ medical programs for (name) _____ ( other names known by) _____ birth date: _____ with the professionals or agencies listed below for the purpose of coordination of care. Records released may include all information concerning any testing, diagnosis or treatment related to HIV, STD, psychiatric and/or drug/alcohol. A photocopy of this document shall be considered to be as valid as the original.

People who help you with your care (including: primary physician, public health nurse, therapists, specialists, and other agencies)

| Contact Person's Name | Agency/Clinic Name & Address (if known) | Phone/FAX# |
|---|---|---|
| Doctor (Primary): | | |
| Doctor (Other): | | |
| Hospital: | | |
| PT: | | |
| Chiropractor: | | |
| Counselor: | | |
| School: | | |
| Other: | | |
| Other: | | |

**Rights:**

I understand I do not have to sign this release in order for the patient to receive services (treatment, evaluation, or enrollment). However, I do have to sign a release form in order for _____to share information regarding the patient on my behalf.

**Signed**

(Name) (Date)

EXPIRATION: This release will be valid for the patient's duration of participation in his/her therapy programs and will expire one year after the patient's discharge. This release may be revoked at any time by the above signed through submission of a written and signed statement. Revoking this release of information will not impact information released prior to the date of the written revoke request.