THERAPY INNOVATIONS, LLC

WWW.THERAPY-INNOVATIONS.COM

(414) 241-8008

Client Intake Form

Client Name: Date of Birth:

Primary Phone: Secondary Phone:

Address:

Email address:

School (if applicable): Grade:

Diagnoses /Concerns:

Previous Therapies / Treatments:

Medications, Allergies:

Surgical History:

If client is a Minor and/or Dependent, please complete the following:

Parent(s) or Legal Guardian(s):

Social Security # of Responsible Party:

Mode of Intended Pay:

Referred By:

Complete only if information is different than above.

Primary Phone Secondary Phone:

Billing Address:

Email address:

Physician Information

Primary Physician:

Phone: Fax:

Address:

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Consent to Treat

I hereby authorize Therapy Innovations, LLC. to perform occupational therapy evaluations, administer therapeutic treatments, and provide clinical consultative services as deemed necessary by therapist. I understand that Occupational Therapy is not a substitute for standard medical care and there's no stated guarantee for effectiveness of treatment.

Signature: Date:

Printed Name: Relationship to Client:

Policies & Fees

- Payment is required at the time of service unless payment arrangements have been made.
- Therapy Innovations, LLC is not a Medicaid-certified provider and is out of network for all insurance plans. A detailed invoice will be provided at client's request to submit to insurance carrier. Any reimbursement is then paid directly to the insured and not the provider.
- If payment has not been received on the account for 45 days, and payment arrangements have not been made, we reserve the right to suspend therapy sessions until appropriate payment has been posted to account.
- Fees are based on Private Pay or Waiver eligibility and include charges for evaluation ($175-$250), treatment ($115-$165/ hour), and consultation, which will depend on frequency, intensity, and duration (Up to $75/hour).

I agree to the above stated policies and fees. I understand it is my responsibility to ensure funding for services received through Therapy Innovations, LLC. I understand that I am responsible for all debt incurred with Therapy Innovations.

Signature: Date:

Printed Name: Relationship to Client: