Achievement Therapy Center
701 E Tudor Rd. Ste 105
Anchorage, AK 99503
Phone : 907-334-9001

NEW PATIENT INTAKE FORM

Personal Information

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: M or F

Legal Guardian 1

Physical Address:

_____

City, State, Zip:

_____

Phone:

_____

Do you text? Y or N

Mailing Address:

_____

City, State, Zip:

_____

Email:

_____

Legal Guardian 2

Physical Address:

_____

City, State, Zip:

_____

Phone:

_____

Do you text? Y or N

Mailing Address:

_____

City, State, Zip:

_____

Email:

_____

Primary Care Physician: _____

Emergency Contact and Relationship: _____

Emergency Phone: _____

If in State Care, Social Worker's Name_____ Phone_____

[ ] By checking this box, I agree to receive SMS messages about appointment information from Achievement Therapy Center at the phone number provided above. The SMS frequency may vary. Data rates may apply. Text HELP for assistance. Reply STOP to opt out of receiving SMS messages. Please review our Privacy Policy and terms of service at aktherapyforkids.com/privacy-policy

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INSURANCE INFORMATION

Primary Insurance

Insurance Company Name: _____ Policy # _____ Group# _____

Policy Holder's Name _____ Employer _____

Policy Holder's DOB _____ Relationship to Insured _____

Insurance Address _____Phone _____

Secondary Insurance

Insurance Company Name: _____ Policy # _____ Group# _____

Policy Holder's Name _____ Employer _____

Policy Holder's DOB _____ Relationship to Insured _____

Insurance Address _____Phone _____

*****Please Provide a copy of your Insurance Card(s) or Medicaid Sticker*****

RELEASE, ASSIGNMENT AND STATEMENT OF RESPONSIBILITY

I authorize Achievement Therapy Center, LLC or/and its agents to bill my insurance carrier directly and agree to be responsible for all amounts not covered by the insurance company. I also agree to allow Achievement Therapy Center, LLC to release any medical records that are requested by the insurance carrier for payment of service. I hereby authorize payment directly to Achievement Therapy Center, LLC for therapy rendered.

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FINANCIAL POLICY STATEMENT

Thank you for choosing Achievement Therapy Center, LLC for services. We are committed to providing you with the best possible care. Your understanding of our financial policy is important to our professional relationship. The following is our Financial Policy, which we require you to read, initial, and sign prior to any treatment. Please ask if you have any questions about our fees, financial policy, or your responsibility. WE ACCEPT CASH, CHECKS, AND CREDIT CARDS.

_____ (Initial) Insurance is a contract between you and your insurance company. You are responsible for the timely payment of your account. Co-payment, if applicable, deductibles and co-insurance is payable at each visit.

_____ (Initial) Achievement Therapy Center, LLC has a policy in place to bill your insurance company as a courtesy. After submitting the claim, we will reserve the portion of your balance that is expected to be covered by your insurance for up to 60 days. However, we require payment of your estimated share at the time of service. If the insurance company has not made payment within 60 days, the remaining balance will become your responsibility. We will not engage in disputes with your insurance company regarding deductibles, co-payments, or covered charges, except to provide information when needed.

_____ (Initial) As a courtesy, Achievement Therapy Center, LLC will verify your insurance coverage and obtain the necessary authorization for our services, either from your Primary Care Physician or directly from your insurance provider's authorization department. Please note that obtaining authorization does not guarantee payment for services until a claim has been processed. If your insurance company does not cover the charges, payment will be due upon receipt of services.

_____ (Initial) Payment of all outstanding accounts is due in full before discontinuing therapy with Achievement Therapy Center, LLC regardless of outstanding insurance payments. No information will be released from this office until the entire balance is paid in full. I understand that in the event payment is not made in a timely manner, information of my delinquent account will be forwarded to the collection agency, which also reports to the credit bureau and a reasonable processing fee will be added to the balance of my account.

_____ (Initial) I understand that I am responsible for communicating to Achievement Therapy Center, LLC of any change in insurance coverage. Failure to do so may result in full responsibility of payment of services.

_____ (Initial) We require a credit card on file for each client. Any outstanding statement balance less than or equal to $150 will be automatically charged on the 1st of each month. Any accumulating balance over $150 requires immediate payment in full or a payment plan agreement on file. Payment plans require a monthly payment of at least 10% of the accrued balance at the time of agreement.

MY SIGNATURE BELOW INDICATES THAT I AGREE TO ALL OF THE ABOVE STATEMENTS.

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CANCELLATION POLICY

Attendance is crucial to achieving your therapy goals, as appointments are considered medically necessary by your primary care physician. We understand that unexpected situations can arise, and appointments may need to be canceled. To maximize availability for all clients, we request that you provide sufficient notice if you need to cancel. This allows us to offer the time to others. Our therapists will make every effort to extend the same courtesy. Thank you for your understanding and cooperation in helping us provide the necessary care to all our clients.

_____ (Initial) As a courtesy, please notify our office at least 24 hours in advance if you need to cancel or reschedule your appointment. For Monday morning appointments, we ask that you notify us by Sunday at 5:00 pm via text or voicemail. Failure to cancel within the required time will result in a fee of $25.00 added to the client account

_____ (Initial) We recognize that you may not be able to provide a 24-hour cancellation notice due to unexpected illness, family emergency, etc. We ask that you try to give your providing therapist as much notice as possible, however these types of cancellations, regarding the above fees, are 100% up to clinic discretion.

_____ (Initial) A No Show is considered failure to cancel or failure to show for a scheduled appointment, a fee of $50.00 will be added to the client account. After 2 “no shows”, Achievement Therapy Center reserves the right to suspend or terminate services.

_____ (Initial) We require a 65% attendance rate and may need to remove the client from the therapist's schedule if efforts are not made to maintain this rate. Note: We calculate attendance quarterly and, as a courtesy, will notify you if your percentage drops below the required 65%.

_____ (Initial) If you need to cancel therapy for an extended period (such as due to vacation or insurance issues), management will review and approve any hold requests on a case-by-case basis.

*For those who are serviced via Medicaid: Appointment no-shows occur across all medical practices, and the Division of Health Care Services (DHCS) acknowledges that this problem can have negative impacts. As mandatory reporters, a “no show” report may be filled out within seven days of the missed appointment. This is to support the DHCS Quality Assurance (QA) Unit work in mitigating these occurrences.

OUR PROMISE

The Therapists at Achievement Therapy Center will make every effort to afford you the same courtesy. This policy enables us to open otherwise unused appointments to better serve the needs of all our clients and provide all our children with the therapies they need and deserve. Thank you for your understanding and cooperation.

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CANCELLATIONS DUE TO ILLNESS

We recognize that you may not be able to provide a 24-hour cancellation notice due to illness, if you or your child are sick, we ask that you try to give the receptionist as much notice as possible. We will provide you with the same courtesy should any of our therapists be ill and unable to provide your scheduled session.

We ask that you use parental discretion for mild illnesses such as a cough or runny nose. For more serious illnesses, we ask that your child be symptom free for 24 hours prior to their next scheduled appointment. (Exceptions may be made with a doctor's note). These symptoms include but are not limited to:

- Diarrhea
- Vomiting
- Fever
- Rashes
- Pink Eye
- Chickenpox
- Lice
- Bedbugs
- Any other illness/infestation that requires medical attention.

Please let the receptionist know of any recent illnesses or injuries that may impact their therapy sessions.

By signing below, you acknowledge that you have read and understand this policy.

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NOTICE OF MANDATED REPORTERS

The therapists at Achievement Therapy Center are all recognized by the State of Alaska as mandated reporters. This means that they are legally obligated to report reasonable suspicions of abuse or neglect in order to protect the children they work with.

Reportable actions include but are not limited to general neglect, physical abuse, verbal abuse, emotional abuse, sexual abuse, and substance abuse. This also includes a parent being under any time of influence in the presence of their child outside of the home, particularly when providing transportation (such as to and from the clinic). Substances continue to qualify a parent or child as under the influence whether the substances are (recreationally) legal or not.

Please know that our therapists recognize that raising children, particularly children with additional needs, is difficult. We applaud our parents for continuing to put in the efforts to assist their children in receiving the services they need, and we want to help our families in any way we can. We are more than happy to provide you with additional resources if needed to assist with overcoming tough obstacles throughout your child's development. These are challenging, yet important conversations to have.

By signing below, you acknowledge that you understand the employees here are mandated reporters and are required by law to report any suspicions of potential abuse in any form.

Please let us know if you have any questions or would like further clarification.

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CONSENT TO TREATMENT

I, _____, give permission for _____ (minor child) to be evaluated by Achievement Therapy Center, LLC (including all occupational therapists, physical therapists, and/or speech therapists on staff). By signing below, I give my consent for examination and the performance of any tests or procedures necessary to evaluate and treat the above minor patient.

Parent/Guardian Signature: _____Date: _____

PHOTO RELEASE (optional)

_____ (Initial) I give permission to Achievement Therapy Center, LLC to photograph/videotape my child for the purposes of evaluation, treatment, plans of care, education and documentation.

_____ (Initial) I give permission to Achievement Therapy Center, LLC to photograph/videotape my child for marketing purposes

Parent/Guardian Signature: _____Date: _____

RELEASE OF LIABILITY

I as the undersigned acting as legal guardian and or legal power of attorney, give my informed consent for child to participate in any Occupational, Physical, or Speech Therapy activity that is conducted in any location, this includes, on-site and community based therapeutic activities. These activities may include but are not limited to sports, water, boats, bicycles, swings, playgrounds, climbing walls, snow, ice, all wheeled recreational items, balls ropes and jumping from various heights, trees, and interaction with other children or persons. I am aware that there are inherent risks in participating in activities that may challenge my child and I accept and am aware of these. In the event of any physical or mental injuries sustained in any activities facilitated by Achievement Therapy Center, LLC and all employees, managers and members of Achievement Therapy Center, LLC are released from all liability. This release of liability is perpetual during the treatment time of the above participation person – beginning date of signature below.

Parent/Guardian Signature: _____Date: _____

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Telehealth Consent

Telehealth therapy allows for remote delivery of pediatric therapy services, including but not limited to speech therapy, occupational therapy, and physical therapy, via electronic means (such as video calls, phone calls, or other secure communication methods). These services are provided by licensed healthcare professionals and are designed to provide the same level of care as in-person sessions, with the added convenience of remote access.

_____ (Initial) I understand that telehealth therapy services involve the use of audio, video, and other forms of electronic communication to deliver healthcare services remotely. These services may include assessments, therapeutic interventions, progress monitoring, and other activities appropriate for remote delivery.

_____ (Initial) I consent to the use of telehealth for my child's therapy services and understand that Achievement Therapy Center will make every reasonable effort to ensure the security and privacy of communications. I understand that telehealth sessions may involve communication with healthcare providers using technologies that may not always be 100% secure. I understand that my child's therapy records will be kept confidential and shared only with authorized individuals, as required by law.

_____ (Initial) I understand that I am responsible for ensuring that the necessary technology (internet connection, device, and software) is in place for telehealth services. Achievement Therapy Center will offer guidance on how to use the technology, but I am ultimately responsible for ensuring it works properly before each session and failure to do so will be considered a late cancel and will result in a late cancellation fee.

_____ (Initial) I understand that the cancellation or rescheduling of telehealth appointments must follow Achievement Therapy Center's cancellation policy for missed or canceled sessions. I agree to notify Achievement Therapy Center according to the cancellation policy if I need to reschedule or cancel any appointment, and I understand that failure to do so will result in a fee.

_____ (Initial) I understand that telehealth services are not appropriate for emergencies. In the event of an emergency, I will seek immediate in-person care or call emergency services (911 or local emergency number).

_____ (Initial) I understand that my child's participation in telehealth services is voluntary and that I may withdraw consent at any time without penalty. If I decide to withdraw from telehealth services, I will notify Achievement Therapy Center, and in-person therapy arrangements will be discussed if appropriate.

***By Alaska telehealth law we are required to ask if you would like for Achievement Therapy Center to send a copy of all teletherapy notes to your child's primary care physician. During regular therapy, we do not typically send your child's notes every session unless requested. Would you like to opt out of sending each note or would you like us to fax each note after every teletherapy session?

_____ Yes, I would like to opt out

_____ No, please send every teletherapy note

By signing below, I acknowledge that I have read and understood the information above. I have had the opportunity to ask questions and receive satisfactory answers. I consent to the provision of telehealth pediatric therapy services to my child. By signing this form, I am giving consent for my child to receive telehealth services from Achievement Therapy Center as part of their treatment plan.

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RELEASE OF INFORMATION

List the names of the programs/people that have worked with or are currently working with your child. Please initial in the last column to authorize communication between Achievement Therapy Center, LLC, and each of the following.

Service	Program Name/Location	Professional's Name	Dates	Authorize Release of Information PLEASE INITIAL
Pediatrician/Physician				
Child Care Program				
Infant Learning Program				
Head-Start Program				
Preschool Program				
Elementary School				
Middle/High School				
Counselors (behavioral or other)				
Public Health Nurse				
Occupational Therapist				
Physical Therapist				
Speech Therapist				
Caseworker				
Other:				
Foster Family				

I give my permission for the exchange of written/electronic/oral communication between my care providers/doctors/insurance companies, and Achievement Therapy Center, LLC. I understand that my child's records may be reviewed by state representatives for the purpose of insurance certification, or by therapists or doctors for the purpose of professional peer review, licensing or quality assurance. I understand that all practices of confidentiality, following HIPPA compliance standards, will be followed in use of the information gathered. I may revoke or limit this permission at any time.

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GENERAL INFORMATION

Person(s) completing form _____ Relationship _____

What are your concerns regarding your child?

_____

_____

_____

_____

_____

When did you first become concerned about your child's development?

_____

_____

Sibling names and ages

_____

_____

Is English the primary language spoken at home? YES NO

(if no, what is the primary language spoken in the home?) _____

Does your child attend preschool / school? YES NO

(if yes, where and what days/times?)

_____

Grade? _____

Does your child have an IEP/IFSP? Y N If yes, please provide a copy.

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MEDICAL HISTORY

Does your child have a medical diagnosis?	Please circle one YES NO	If yes, please list:
Has your child had prior OT/PT/Speech evaluations or treatment for concerns?	YES NO	If yes, please list location and dates:
Do you have any concerns regarding your child's hearing?	YES NO	Date of last exam:
Do you have any concerns regarding your child's vision?	YES NO	Date of last exam:
Is your child currently taking any medication?	YES NO	If yes, please list:
Does your child have any allergies?	YES NO	If yes, please list:

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Has your child had any of the following?

- ❑ Chicken Pox
- ❑ Encephalitis
- ❑ Asphyxia (Oxygen/Breathing Loss)
- ❑ Meningitis
- ❑ Other: _____
- ❑ Asthma
- ❑ Head Injury
- ❑ Seizures
- ❑ Tonsils/Adenoids Removed
- ❑ Other: _____

Please note any major illnesses your child has had and when

_____

_____

Please note any hospitalizations or surgeries, where and when

_____

_____

Gestational/Birth History

Born via (please circle one): C-section or Vaginal

Please describe any unusual circumstances of pregnancy or delivery

_____

_____

Was the child premature? YES NO

How many weeks gestation? _____

Child's birth weight _____