Achievement Therapy Center, LLC

235 E. 9th Ave. Anchorage, Alaska 99501
Phone: 907-334-9001 Fax: 907-868-8657
Email: office@aktherapyforkids.com
Website: aktherapyforkids.com

PATIENT INTAKE / BILLING INFORMATION

Last Name: _____ First Name: _____ MI: _____

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

Parent or Guardian Name(s):

_____

Physical Address: _____

City: _____State: _____ Zip: _____Phone: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Do you text? Y or N

Primary Care Physician: _____

Emergency Contact: _____ Phone: _____

If in State Care, Social Worker's Name_____ Phone_____

Signature to release information & work with Assigned Foster Family*

X_____

Respite worker? Name: _____ Phone: _____

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*****

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 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.

INSURANCE

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. *Achievement Therapy Center, LLC* maintains an office policy to bill your insurance company as a courtesy to you. Once the carrier is billed, we will set aside the portion of the balance estimated to be paid by your insurance carrier for 60 days. We require that your estimated share be paid at the time the services are rendered. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you at that time. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments or covered charges other than to supply factual information as necessary. *Achievement Therapy Center, LLC* will obtain verification of insurance and follow up with authorization for our services whether from your Primary Care Physician or directly from your insurance policy authorization department. Please be advised, an authorization for services does not guarantee payment of services rendered until an actual claim is received. If your insurance company will not cover the incurred charges, payment is due upon receipt of services. 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.

_____ (Initial) 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.

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

Parent/Guardian Signature _____ Date _____

CANCELLATION POLICY

CANCELING AN APPOINTMENT

We understand that unforeseen or extenuating circumstances can occur, and sometimes appointments need to be cancelled. We want to make sure that all appointment times are able to be used, and so we require sufficient notice for cancelled appointments to allow the appointment to be offered to other clients, if possible.

Please Contact the Clinic and/or Providing Therapist via phone or email **AT LEAST 24 HOURS** prior to your scheduled appointment date and time to avoid cancellation fees.**

Cancellation is required 24 hours prior to appointment; failure to cancel within the required time will result in a fee of **$25.00 being charged to the credit card on file. A No Show is considered failure to cancel or failure to show for a scheduled appointment, a fee of **$50.00** will be applied to the credit card on file by end of the business day for said appointment.

As we try to be as flexible as possible, our therapists want to be available for your individual needs and the needs of all our clients. When a child is not present for a scheduled appointment, another child loses an opportunity to be seen. By signing this form, you acknowledge your understanding of the above statements. **After 3 "no shows," Achievement Therapy Center has the right to suspend or terminate services. Additionally, excessive last-minute cancellations or attendance that falls below 50% is at risk for termination of services. ***

*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.

EXTENUATING CIRCUMSTANCES (less than 24 hours – per clinic discretion)

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.

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.

Parent/Guardian Signature _____ Date _____

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.

Child's Name _____

Parent/Guardian Signature _____ Date _____

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.

Parent/Guardian Signature _____ Date _____

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.

Parent/Guardian Signature _____ Date _____

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

_____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.

_____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.**

Child Name: _____ Date of Birth _____

Parent/Guardian Signature _____ Date _____

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:				
Other				
Other				
Foster Family				

MEDICAL RELEASE OF INFORMATION

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.

Parent/Guardian Signature _____ Date _____

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.

MEDICAL HISTORY

Does your child have a medical diagnosis? 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: _____

Was the child premature? YES NO Weeks gestation? _____ Child's birth weight _____
Did mother have any illnesses or infections during pregnancy? YES NO

If yes, please describe: _____

Were there any complications during delivery? YES NO Born via: C-section or Vaginal

Describe:_____

MEDICAL HISTORY CONTINUED

Did your child require any medical procedures before, during, after birth? YES NO

If yes, please describe: _____

Extended hospital stay in NICU or PICU? _____ If so, how long? _____ Intubation? ____ Oxygen? ____

Please describe any unusual circumstances of pregnancy or delivery

_____

_____

Please note any major illnesses your child has had and when

_____

_____

Please note any hospitalizations or surgeries, where and when

_____

_____

Has your child had any of the following?

____ Chicken Pox ____ Encephalitis ____ Asphyxia (Oxygen/Breathing Loss) ____ Meningitis

____ Asthma ____ Head Injury ____ Seizures ____ Tonsils/Adenoids Removed