815 E. Warner Road, Suite 106
Chandler, AZ 85225
AzAdvancedTherapy@gmail.com

p. 480.963.5800
f. 480.963.5805

CLIENT INFORMATION FORM

CLIENT'S NAME:_____

DATE OF BIRTH: _____ SEX: M / F

HOME ADDRESS: _____

CITY, STATE, ZIP: _____

HOME PHONE: _____

RESPONSIBLE PARTY CONTACT INFORMATION:

PARENT/GUARDIAN NAME: _____

ADDRESS (if different from above):_____

CITY/STATE/ZIP: _____

PARENT/GUARDIAN EMPLOYER: _____

CELL PHONE: _____ WORK PHONE: _____

E-MAIL: _____PRIMARY CONTACT: YES ☐ NO ☐

PARENT/GUARDIAN NAME: _____

ADDRESS (if different from above):_____

CITY/STATE/ZIP: _____

PARENT/GUARDIAN EMPLOYER: _____

CELL PHONE: _____ WORK PHONE: _____

E-MAIL: _____ PRIMARY CONTACT: YES ☐ NO ☐

NAME OF PRIMARY CARE PHYSICIAN (PCP): _____

PEDIATRIC GROUP NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE: _____ FAX: _____

PRIMARY CARE PHYSICIAN E-MAIL: _____

PLEASE LIST ADDITIONAL COMMENTS OR INFORMATION THAT YOU FEEL ARE HELPFUL/IMPORTANT.

_____

_____

Date: _____

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For DES/DDD consumers with private insurance, DES/DDD requires that your private insurance company is billed prior to billing DES/DDD.

DOES THE CLIENT HAVE DDD? **YES** ☐ **NO** ☐

If yes, provide DDD Support Coordinator's Name? _____

Phone Number: _____Email:_____

PRIMARY INSURANCE:

INSURED'S NAME: _____

RELATIONSHIP: _____ BIRTHDATE: _____ SSN: _____

EMPLOYER: _____ INSURANCE COMPANY: _____

GROUP#: _____ ID#: _____

INSURANCE COMPANY ADDRESS: _____

CITY, STATE, ZIP: _____

INSURANCE COMPANY PHONE NUMBER:_____

SECONDARY INSURANCE:

INSURED'S NAME: _____

RELATIONSHIP: _____ BIRTHDATE: _____ SSN: _____

EMPLOYER: _____ INSURANCE COMPANY: _____

GROUP#: _____ ID#: _____

INSURANCE COMPANY ADDRESS: _____

CITY, STATE, ZIP: _____

INSURANCE COMPANY PHONE NUMBER:_____

AUTHORIZATION AND RELEASE

I authorize Arizona Advanced Therapy to release any information including the diagnosis and the records of any treatment or examination rendered during the period of such care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to Arizona Advanced Therapy or group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf for my dependent(s).

_____ _____

SIGNATURE OF RESPONSIBLE PARTY **PRINTED NAME**

_____

DATE

Please provide a copy of your insurance card(s), both front and back.
Thank you for your cooperation.

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INFORMATION NEEDED TO REQUEST PRIOR AUTHORIZATION

Diagnosis: _____

Are you looking to be seen at: HOME ☐ CLINIC ☐

Please provide Primary Care Physician script with diagnosis code and therapy service(s) recommendation, in addition to any previous Plan of Care, evaluation(s), or progress report(s).

Current Medication(s): _____

_____

Please list any allergies to medications, food, latex, etc.: _____

_____

What concerns brought you to Arizona Advanced Therapy? _____

_____

Has your child been seen for therapy prior to today? If yes, where and when: _____

_____

Does your child use or need any adaptive equipment or device? If yes, please describe:

_____

_____

Please state any additional concerns and/or questions:

_____

_____

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CANCELLATION POLICY

If you need to cance,l please notify your therapist and/or the clinic **24 hours prior to your scheduled appointment.** With 2 or more no shows or cancellations with less than 24 hours notice in a 30-day period, you will be dismissed from your current scheduled appointment time. It is your responsibility during that time to call and schedule appointments with your therapist.

_____ _____
Parent or Legal Guardian's Signature Date

CONFIDENTIALITY POLICY

All employees, staff, contractors, and agents of our practice will be trained to respect the health care information of the patients of our practice. They will treat all medical, personal, and financial information as confidential.

I have read this statement.

_____ _____
Parent or Legal Guardian's Signature Date

PERMISSION TO CONTACT OTHER PROFESSIONALS

I, _____, as parent and/or legal guardian of

_____ (Client's Name), hereby give my permission to

Arizona Advanced Therapy and/or _____(Therapist's Name) to contact by phone, mail, e-mail or FAX any of the other team members who are, or have been, involved in the care of the client listed above, such as the Primary Care Physician, DDD Support Coordinator, or other therapy providers. It is understood that the information shared by these methods and between these involved professionals will be used in a confidential and professional manner in the best interest of the client.

_____ _____
Parent or Legal Guardian's Signature Date

Exceptions: _____

This authorization waives the right to legal action with regard to the release of such information as may be requested.

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ACCEPTANCE OF ELECTRONIC COMMUNICATION

Client's Name: _____Date of Birth: _____

I request that the following communications from Arizona Advanced Therapy ("AAT") be delivered to me and/or someone else via e-mail at the e-mail address noted below OR via text message to the phone number noted below. Messages may be from AAT (anyone) or the assigned Therapist. I understand that these forms of communication may NOT be secure, creating a risk of improper disclosure of Personal Health Information (PHI) to unauthorized individuals.

Electronic communication may be regarding any of the following:

- ► Schedule Change / Appointment Reminder
- ► Invoicing (if necessary)
- ► Progress Report(s)
- ► Clinic Related Issues / Information
- ► Insurance Questions / Information

My e-mail address: _____

Additional contact's e-mail address: _____

Name of person at additional contact's e-mail address: _____

My telephone number for text messages: _____

Additional contact's phone number for text messages: _____

Name of person at additional contact's phone number: _____

ACKNOWLEDGEMENT AND AGREEMENT:

I understand that these communications may involve transmission of Protected Health Information (PHI), and agree that the requested communication method(s) is/are NOT secure, making the PHI at risk for receipt by unauthorized individuals. I am willing to accept that risk and will NOT hold AAT responsible should such incident occur.

Signed: _____ on Date: _____

Printed Name: _____

Address:_____ / _____

Relationship to Client: _____

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LATE PAYMENT POLICY

A $15 late fee will be assessed if you are more than 30 days past due on your account. Therapy will also be suspended until payments are made. The scheduled therapy day and time prior to suspension are not guaranteed if and when therapy services are reinstated. If you are unable to make a payment within this timeframe, please contact Arizona Advanced Therapy ("AAT") at 480.963.5800 to discuss a payment plan.

Should a payment made to AAT by you (or someone else on behalf of you for your child's treatment) be returned for "insufficient funds" cause AAT to be charged a fee, said fee will be billed back to you and will be your responsibility to pay. The late payment policy above WILL be applied to this fee, should your account remain past due as stated above.

I have read and agree to be responsible for payment of all services.

_____

Client/Patient/Child's Name

_____ _____

Parent or Legal Guardian's Signature Date

Currently, we accept payments via CHECK, CASH, or through PAYPAL (family will be responsible to pay the PayPal processing fee). Please make checks payable to Arizona Advanced Therapy.

I prefer to receive my invoices by (circle one): PAPER MAIL E-MAIL

Please list the preferred mailing address or email address to send invoices to below:

MAILING ADDRESS: _____

CITY, STATE, ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

E-MAIL: _____

Thank you for taking the time to complete this New Client Information Form.

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PAST MEDICAL HISTORY

DIAGNOSIS: _____

MEDICAL HISTORY

Were any of these conditions encountered during the pregnancy?

	Yes	No		Yes	No
Bleeding	☐	☐	Maternal Seizure Disorder	☐	☐
Limited Weight Gain	☐	☐	Maternal Alcohol Use	☐	☐
Excessive Weight Gain	☐	☐	Maternal Drug Abuse	☐	☐
Pre-Eclampsia	☐	☐	Pre-Term Labor	☐	☐
Gestational Diabetes	☐	☐			

What was the length of the pregnancy? _____
Please list any medications taken during your pregnancy: _____
Please specify any other complications during the pregnancy: _____

Was the delivery or birth marked by any of the following?

	Yes	No		Yes	No
Difficult Birth	☐	☐	Reduced Apgar scores	☐	☐
Brief Labor	☐	☐	Baby required oxygen	☐	☐
Prolonged Labor	☐	☐	Baby jaundiced (yellow)	☐	☐
Mother required oxygen	☐	☐	RH Incompatibility	☐	☐
Cesarean Section	☐	☐	Baby had difficulty sucking	☐	☐
Breech Birth	☐	☐	ROP	☐	☐
Cord around baby's neck	☐	☐	Discharged on an apnea monitor	☐	☐

What was the baby's birth weight? _____
Did the baby receive an OAE hearing screen? _____
How long was the baby in the hospital before the discharge? _____

Did your child experience any of the following during infancy?

	Yes	No		Yes	No
Trouble Sleeping	☐	☐	Excessive Crying	☐	☐
Trouble sucking/swallowing	☐	☐	Diarrhea/Vomiting	☐	☐

Please indicate if your child has experienced any of the following:

	Yes	No		Yes	No
Asthma	☐	☐	Encephalitis	☐	☐
Allergies	☐	☐	Meningitis	☐	☐
Failure to thrive	☐	☐	Pneumonia	☐	☐
Seizure disorder	☐	☐	Heart Disease	☐	☐
Eye Disorders	☐	☐	Cerebral Palsy	☐	☐
BPD	☐	☐	Hernia	☐	☐
Hospitalization	☐	☐	Any additional comments: _____		
Surgery	☐	☐	_____		

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Has your child experienced middle ear infections? If yes, please indicate the following:

Number of ear infections: _____
Child's age at the time of first ear infection: _____
Child's age at the most recent ear infection: _____
Type of treatment: _____
ENT Specialist's Name: _____

Has your child experienced hospitalizations and/or surgeries? If yes, please explain the reason for hospitalizations and/or surgeries:

_____

_____

DEVELOPMENTAL HISTORY

Please check the items that apply for your child's age/developmental level

Gross Motor Skills	**Yes**	**No**	
Held head up by 2 months?	☐	☐	Age when achieved: _____
Rolled over by 3 to 4 months?	☐	☐	Age when achieved: _____
Sat alone by 6 to 7 months?	☐	☐	Age when achieved: _____
Crawled by 7 to 8 months?	☐	☐	Age when achieved: _____
Pulled to stand 9 months?	☐	☐	Age when achieved: _____
Walk alone by 12 to 14 months?	☐	☐	Age when achieved: _____
Fine Motor Skills	**Yes**	**No**	
Grasped objects by 4 months?	☐	☐	Age when achieved: _____
Transferred objects in by 7 months?	☐	☐	Age when achieved: _____
Demonstrated hand preference by 3 yrs?	☐	☐	Age when achieved: _____ L or R
Toilet trained by 3 ½ yrs?	☐	☐	Age when achieved: _____
Does your child dress him/herself?	☐	☐	Age when achieved: _____
Does your child tie his/her shoes?	☐	☐	Age when achieved: _____
Is your child interested in coloring & cutting?	☐	☐	Age when achieved: _____
Does your child tolerate tooth brushing?	☐	☐	Age when achieved: _____
Communication Skills	**Yes**	**No**	
Cooed and babbled as an infant?	☐	☐	Comments: _____
Used first words by 14 months old?	☐	☐	Comments: _____
Put 2 words together by 2 yrs old?	☐	☐	Comments: _____
Used simple sentences by 3 yrs old?	☐	☐	Comments: _____
Does your child follow simple directions?	☐	☐	Comments: _____
Does your child answer simple questions?	☐	☐	Comments: _____
Does your child listen to stories?	☐	☐	Comments: _____
Is your child's speech difficult to understand?	☐	☐	Comments: _____
Are there specific sounds that are a problem?	☐	☐	Comments: _____
Is communication frustrating for your child?	☐	☐	Comments: _____
Does your child use or understand more than one language?	☐	☐	Comments: _____

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HEARING STATUS	**Yes**	**No**
Have you ever questioned your child's hearing?	☐	☐
Has your child had a hearing test?	☐	☐

Please state where, when and the results of hearing test: _____

_____

VISION STATUS	**Yes**	**No**
Have you ever questioned your child's vision?	☐	☐
Has your child had an eye exam?	☐	☐

Please state where, when and the results of vision test: _____

_____

EDUCATIONAL HISTORY	**Yes**	**No**
Is your child currently in preschool/school?	☐	☐
Does your child receive therapy in school?	☐	☐

School and Grade: _____
School District: _____
If yes, which therapies: _____

BEHAVIORAL HISTORY	**Yes**	**No**
Does your child exhibit the following:		
Attention problems	☐	☐
Hyperactivity	☐	☐
Temper Tantrums	☐	☐
Shy or Withdrawn Behavior	☐	☐
Poor eye contact	☐	☐
Difficulty getting along with other children	☐	☐
Disruptive behavior	☐	☐
Immaturity for age	☐	☐
Social or sexual inappropriateness for age	☐	☐

Other behavioral concerns: _____

FAMILY HISTORY	**Yes**	**No**
Is there any family history of the following:		
Speech/language delay	☐	☐
Hearing Impairment	☐	☐
Learning Disability	☐	☐
Seizure Disorder	☐	☐
Congenital Disorder	☐	☐

Thank you for taking the time to complete this developmental history.