

ADVANCED THERAPY SOLUTIONS

EXCEEDING EXPECTATIONS...

OFFICE INTAKE

A.T.S. must have this page filled out completely by a parent or legal guardian BEFORE any Evaluation can be initiated.

PATIENT'S NAME : _____ DATE OF BIRTH : _____ SS #: _____

PARENT OR GUARDIAN'S NAME: _____

PRIMARY PHYSICIAN OR GROUP : _____

PRIMARY INSURANCE COMPANY: _____

PRIMARY INSURED'S NAME _____ DATE OF BIRTH : _____ SS #: _____

SECONDARY INSURANCE COMPANY: _____

SECONDARY INSURED'S NAME : _____ DATE OF BIRTH : _____ SS #: _____

IF INSURANCE IS TRICARE: STANDARD or PRIME (please circle one)

DOES THIS PATIENT HAVE INSURANCE THROUGH ANOTHER PARENT OR GUARDIAN? YES or NO (circle one)

IF YES, INSURANCE COMPANY NAME IS _____

PRIMARY INSURED'S NAME IS _____ DATE OF BIRTH : _____ SS #: _____

DOES THIS PATIENT HAVE THEIR OWN INSURANCE (example TennCare) ? YES or NO (circle one)

IF YES, INSURANCE COMPANY NAME IS _____

PRIMARY INSURED'S NAME IS _____ DATE OF BIRTH : _____ SS #: _____

DID YOU CALL YOUR INSURANCE COMPANY TO SEE IF THE SERVICES PROVIDED HERE ARE COVERED FOR THE PATIENT?

YES or NO (circle one)

FAILURE TO PROVIDE ALL INSURANCE INFORMATION WILL RESULT IN THE PARENT/GUARDIAN BEING RESPONSIBLE FOR ALL FEES ASSOCIATED WITH EVALUATIONS AND THERAPIES. (to show that you have read the following two statements, write your initials in the blank to the left)

_____ I UNDERSTAND I AM RESPONSIBLE FOR ANY BALANCE THE INSURANCE COMPANIES DO NOT PAY

_____ I WILL INFORM A.T.S. OF ANY CHANGES TO INSURANCE POLICIES, ADDITIONAL INSURANCE OR LOSS OF INSURANCE COVERAGE AS SOON AS CHANGES ARE MADE

PATIENT OR PATIENT'S PARENT OR GUARDIAN MUST PROVIDE ATS OFFICE WITH THE FOLLOWING:

- COPY OF DRIVER'S LICENSE
- COPY OF INSURANCE CARD(s) (OR MILITARY ID)

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EXCEEDING EXPECTATIONS...

Consent for Services

I, the undersigned, authorize Advanced Therapy Solutions, LLC to provide ABA Therapy, Behavioral Health, Occupational Therapy, Physical Therapy, Speech Therapy & Feeding Therapy services for me/my child. I also consent for the release of all medical, ABA, Behavioral Health, Occupational Therapy, Physical Therapy, Speech Therapy & Feeding Therapy information for the purposes of medical treatment, payment, and for regulatory agencies.

Printed name of client

Date

Signature of client or legal guardian

Relationship to client

ADVANCED THERAPY SOLUTIONS

EXCEEDING EXPECTATIONS...

Authorization to Release Medical Information

I, the patient, parent, or legal guardian, authorize the release of information for the purpose of medical treatment, payment, for regulatory agencies, and care coordination for:

First MI Last Date

Street Address City State Zip

Releasing Agent		
_____ Organization		
_____ Address		
_____ City	_____ State	_____ Zip
_____ Phone	_____ Fax	

Receiving Agent		
_____ Advanced Therapy Solutions, LLC		
_____ Address		
_____ City	_____ State	_____ Zip
_____ Phone	_____ Fax	

Advanced Therapy Solutions may release the following medical information:

- | | | |
|---|---|--|
| All <input type="checkbox"/> | History and Physical <input type="checkbox"/> | Demographic Information <input type="checkbox"/> |
| Evaluations <input type="checkbox"/> | Test results <input type="checkbox"/> | Behavioral Health Information <input type="checkbox"/> |
| Therapeutic office notes <input type="checkbox"/> | Discharge Summary <input type="checkbox"/> | Verbal <input type="checkbox"/> |

Print name _____ Date _____

Sign name _____ Date _____

The therapists at Advanced Therapy Solutions LLC consult with parents in the waiting room & other open areas. If you are uncomfortable with this, we can arrange something different for you, but please notify staff in the front office as soon as possible.

Authorization may be revoked at any time per the discretion of the patient, parent or legal guardian of the above aforementioned by signing below:

Signature _____ Date _____

ADVANCED THERAPY SOLUTIONS

EXCEEDING EXPECTATIONS...

Financial Policy

Thank you for choosing Advanced Therapy Solutions as your Speech, Occupational & Physical Therapy provider. We are committed to providing the best possible treatment for our patients. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require all patients or legally responsible individuals to read and sign prior to evaluation or treatment. All patients must also complete our Office Intake Information and Insurance Form before being evaluated or treated.

It is a courtesy of our office staff to file claims for our patients, but an insurance policy is a contract between the patient and the insurance company. We cannot guarantee payment of your claims. Reduction or rejection of insurance claims does not relieve your financial obligation.

Adult patients are responsible for full payment of service.

The adult accompanying a minor and/or the parents (or guardians of the minor) are responsible for payment at the time of service if required.

All co-pays, deductibles and co-insurances are due at the time of service.

Our office accepts: VISA, MASTERCARD, DISCOVER, CASH & DEBIT CARDS

I acknowledge responsibility for payment for all medical fees regardless of any insurance I may have to assist me in this responsibility. I assign all medical benefits payable to Advanced Therapy Solutions. I understand that I am responsible for full payment, unless I am under the coordination and care of services through Tennessee's Early Intervention System (TEIS), for all non-covered charges. If my insurance carrier does not pay the charges submitted by Advanced Therapy Solutions in a timely manner (within 90 days), I understand that I am responsible for full payment. Should I become delinquent on these bills, I give permission for information to be released to the appropriate credit reporting agencies. In the event that charges incurred are not paid in full when due and collection activity is instituted, whether by a collection agency or an attorney (or both), I will be responsible for all costs including, but not limited to, collection fees, attorney's fees, skip tracing costs and court costs. The amount I owe will not be less than 35% of total costs.

I have read, understand and agree to the above Financial Policy.

Patient or Responsible Party Date

Co-Responsible Party Date

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

ADVANCED THERAPY SOLUTIONS

EXCEEDING EXPECTATIONS...

HEALTH AND ILLNESS POLICY

Advanced Therapy Solutions follows the Health Department's guidelines for the childcare program setting. A child is not to be brought to therapy if any of the following symptoms are observed in the past 24 hours.

- *Fever and sore throat, rash, vomiting, diarrhea, earache, irritability, or confusion. Fever is defined as having a temperature of 100 degrees or higher taken under the arm, 101 degrees if taken orally, or 102 degrees if taken rectally.
- *Diarrhea with runny, watery, or bloody stools.
- *Vomiting two or more times in a 24 hour period.
- *Body rash or bumps with fever.
- *Sore throat with fever and swollen glands
- *Severe coughing with redness or blue in the face or makes high-pitched whooping sound after coughing
- *Eye discharge-where thick mucus or pus is draining from the eye, or pine eye, conjunctivitis (yellowish discharge from eyes)
- *Yellowish skin or eyes
- *Lice, scabies, or other parasitic infestation
- *Difficult or rapid breathing
- *Stiff neck
- *Ring worms
- *Discoloration of nasal drainage
- *Irritable, continuously crying, or requires more attention than the therapist can provide.

In order to ensure the health and welfare of all the children at our facilities and to decrease the amount of illnesses, **YOUR CHILD SHOULD HAVE A NORMAL TEMPERATURE OF 98.6 FOR 24 HOURS BEFORE HE/SHE COMES TO THERAPY.**

The therapist has the option to refuse services to a sick child.

Thank you for your cooperation. Our goal is to help your children and keep them healthy and safe.

ADVANCED THERAPY SOLUTIONS

EXCEEDING EXPECTATIONS...

ATTENDANCE POLICY

CANCELLATIONS:

- If you must cancel an appointment for a reason other than sudden illness, you must contact our office or let your therapist know 24 hours before your scheduled appointment
- If you are to cancel three scheduled therapy sessions for non-medical emergencies without giving adequate prior notification to your therapist, it will be at the discretion of Advanced Therapy Solutions whether or not to terminate services.

NO SHOWS:

- Failure to cancel or to appear during an appointment time is considered a "no show". A \$15 fee will be assessed. Please contact our office immediately to discuss future appointments.
- If three (no shows) occur, the patient's appointment time will be automatically offered to another patient waiting for services.

A NOTE FROM THE THERAPIST:

We expect for you to make every effort possible to attend your scheduled appointments. When we establish a plan of care for the patient, we base our goals on the patient having consistency. If the patient misses appointments, they will not meet their goals as quickly, and will have to be enrolled in therapy for a longer period of time. The success of our treatment sessions depends on consistency. In the event that you do have to cancel, we strongly encourage you to reschedule, even if it is with another therapist. We actually enjoy when another therapist sees one of our patients because it gives us another opinion of ideas for the patient. We are always in close communication with each other. Any other concerns you may have, please discuss this with your therapist.

I have read and understand the attendance policy of Advanced Therapy Solutions:

Signature _____ Date _____

ADVANCED THERAPY SOLUTIONS

EXCEEDING EXPECTATIONS...

Notice of Privacy and Security Practices: Acknowledgement of Receipt

I, the undersigned, acknowledge that I understand Advanced Therapy Solutions Notice of Privacy & Security Practices. Our Notice of Privacy & Security Practices provides you with information about how we may use or disclose your protected health information (PHI). The Notice also explains how you can access, amend, and restrict your protected health information. We encourage you to read it in full. **It is available for you to read in full upon request or on our website (advancedtherapy.net).**

Printed name of client

Date

Signature of client or legal guardian

Relationship to client

ADVANCED THERAPY SOLUTIONS

EXCEEDING EXPECTATIONS...

Pediatric Speech Therapy Evaluation CASE HISTORY

CHILD'S NAME: _____ D.O.B.: _____ SEX: _____ AGE: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

PHONE: HOME: _____ WORK: _____ OTHER: _____

Email: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship: _____ Phone#: _____

Alternate Phone#: _____ Work Place: _____

FAMILY INFORMATION:

FATHER/GUARDIAN Name _____ Age ____ Occupation _____

MOTHER/GUARDIAN _____ Age ____ Occupation _____

SIBLINGS: (NAMES/AGES) _____

With whom does the child spend most of his or her time? _____

Does your child attend school/daycare? _____ Where? _____ How often? _____

REFERRAL:

WHO REFERRED YOU FOR THIS EVALUATION (doctor's name)? _____

BACKGROUND INFORMATION:

Describe your primary concern(s) regarding your child? _____

At what age did you first become concerned? _____

Are there any other family members with a history of developmental concerns? (e.g. mental deficits, learning deficits, cerebral palsy) _____

Parent, legal guardian, or authorized person must bring child to the office for therapy, unless otherwise notified by therapist.

Parent Signature _____ Date _____

ADVANCED THERAPY SOLUTIONS

PREGNANCY, BIRTH AND HEALTH

HEALTH OF MOTHER DURING PREGNANCY _____

DURATION OF PREGNANCY _____

NUMBER OF PREGNANCIES PRIOR TO THE BIRTH OF THIS CHILD _____

TOTAL NUMBER OF PREGNANCIES _____

DURING PREGNANCY, DID THE MOTHER EXPERIENCE ANY OF THE FOLLOWING CONDITIONS

check mark all that apply:

___ HIGH FEVERS ___ HOSPITALIZATIONS ___ ACCIDENTS ___ GERMAN MEASLES

___ ILLNESS ___ BLEEDING ___ OTHER CONDITIONS (please explain)

BIRTH:

Length of Labor ___ Was labor induced? _____ Birth Weight ___

The delivery was: ___ normal ___ caesarian ___ forceps ___ breech

Were any of the following conditions evident at birth **check mark all that apply:**

___ jaundice ___ drug addiction ___ intensive care

___ anoxia(blue) ___ feeding difficulties ___ special monitoring

HEALTH:

Has your child's health generally been good? ___ If not, please explain:

Provide approximate ages at which patient had the following illnesses/conditions:

Adenoidectomy _____ Asthma _____ Chicken pox _____

Colds _____ Croup _____ Dizziness _____

Draining Ear _____ Ear Infections _____ Encephalitis _____

German Measles _____ Headaches _____ Hearing Loss _____

High Fever _____ Influenza _____ Mastoiditis _____

Noise Exposure _____ Otosclerosis _____ Pneumonia _____

Seizures _____ Sinusitis _____ Tinnitus _____

Tonsillectomy _____ Tonsillitis _____ Other _____

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EXCEEDING EXPECTATIONS...

HEALTH continued

Patient has taken/is taking medications regularly (please list type and duration) :

Allergies? (please list):

List surgeries and hospitalizations (give approximate dates):

List significant illnesses and infection (give approx. dates):

List past and present medications:

If your child has been seen by any of the following specialists, please mark the service provided and any diagnosis determined (if applicable),

	Testing/Evaluation	Treatment	Diagnosis
Psychologist	_____	_____	_____
Psychiatrist	_____	_____	_____
Otolaryngologist	_____	_____	_____
Neurologist	_____	_____	_____
Geneticist	_____	_____	_____
Dev. Pediatrician	_____	_____	_____
Surgeon	_____	_____	_____
Other	_____	_____	_____

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DEVELOPMENTAL HISTORY

At what **age** did your child:

Crawl _____ Sit up _____ Stand _____ Walk _____ Feed self _____

Use single words (e.g. no, mom, doggie) _____ Dress self _____ Use Toilet _____

Combine Words (e.g. me go, daddy shoe) _____ Name simple objects _____

Use simple questions (e.g. Where's doggie/) _____ Engage in conversation _____

Did/does your child have difficulty:

Sucking? _____ Swallowing? _____ Chewing? _____ Changing to solids? _____

When did you first become concerned? _____ Who first noticed the problem? _____

Has your child received any services from the following agencies (if so, explain):

*Bill Wilkerson Center _____ Type of service _____ Clinician _____

*Tennessee Early Intervention Services _____ Representative _____

*Public Schools/Special Education _____

* Private Speech/Language Pathologist _____

*Hospital Based Speech/Language Services _____

Did your child seem to hear when he/she was an infant? _____

Has your child's hearing been tested? _____ By whom? _____

What were the results? _____

Was medical intervention recommended, and if so, what?

Have you followed this recommendation and if so, how? _____

Do you have any concerns about your child's hearing? _____

Does your child hear _____

Does your child hear *everything*? _____ *most things*? _____ *very little*? _____

Does your child understand what is said?