



NEW PATIENT INTAKE

(Please complete and return)

Patient Name: _____ Gender: M F

Date of Birth: _____ Patient SSN: _____

Address/City/State/Zip: _____

Patient Diagnosis/Chief Complaint: _____

Parent/Guardian Name(s): _____

Home Phone: _____ Mobile Phone: _____

Email: _____

Responsible Party: (parent/guardian responsible for patient's bill)

Name: _____ Date of Birth: _____

SSN: _____ Relationship to child: _____

Home Phone: _____ Mobile Phone: _____

In Case of Emergency Contact Information:

Name: _____

Relationship to child: _____

Home Phone: _____ Mobile Phone: _____

Name: _____

Relationship to child: _____

Home Phone: _____ Mobile Phone: _____

Primary Care Physician: _____

PCP Phone Number: _____

PCP Address: _____

Insurance Information:

Arkansas Medicaid / SoonerCare Number: _____

Private Insurance Name: _____

Claims Address: _____

Telephone: _____

Policy Number: _____

Policy Holder's Name: _____

Policy Holder's SSN#: _____

Policy Holder's DOB: _____

- Please provide copy of AR Medicaid/SoonerCare and/or Private Insurance Card(s)
- Please provide copy of Driver's License

I, _____ am the contact person for all scheduling of this child's therapy times. The therapist shall contact me for any changes in therapy sessions.

I, _____ am responsible for all scheduled treatment sessions. Any scheduling changes or cancellations will be my responsibility. I have read, understand and agree to the terms of the cancellation policy that was given to me.

Please list the name and phone number of any person(s) who will be responsible for dropping off the child or picking up the child from therapy sessions (a copy of each person's driver's license will be required).

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

PHOTO PERMISSION: (Please initial and date)

1. I give permission for photograph/video of my child for the purposes of treatment, education, and documentation. _____ / _____
 2. I give permission for photograph/video of my child to be used for advertising, brochure, internet (clinic website, Facebook, etc.) _____ / _____
-

I hereby give In-Sync Pediatric Therapy Center permission to evaluate and treat my child and understand there will be written, oral and electronic communication between care providers, physicians, insurance companies, and In-Sync Pediatric Therapy staff. I understand that all practices of confidentiality will be followed in use of the information gathered.

Signature of Parent/Guardian of Patient

Date

How did you hear about us? (Please circle any and all that apply)

Physician

Phonebook

Internet Search

Friend

Website

Television

Facebook Page

Radio

Twitter

Other: _____



HISTORY INTAKE FORM

(Please complete and return)

Please answer the questions to the best of your ability and in as much detail as possible. Please add any information that you feel is important but is not covered on this form.

Patient Name: _____ Gender: M F DOB: _____

Diagnosis: _____ Primary Phone: _____

Mother's Name: _____ Work Phone: _____

Father's Name: _____ Work Phone: _____

Guardian's Name: _____ Message #: _____

Siblings Names and Ages: _____

Who is the patient's primary care giver? _____

Has the patient received any previous therapy? _____ Yes _____ No If Yes:

When: _____ How Long: _____

Where: _____ Date of last evaluation: _____

Does the patient attend daycare, preschool, or school: _____ Yes _____ No

If Yes, Where: _____

What languages are used in the home? _____

HEALTH OF MOTHER DURING PREGNANCY

1. Any illnesses or accidents: _____ Yes _____ No If yes, please explain: _____

2. Any medications: _____ Yes _____ No If yes, what: _____

3. Pregnancy: _____ months

4. Labor: _____ hours

5. Baby was delivered: _____ Cesarean _____ Vaginal

6. Baby's birth weight: _____ lbs. _____ ounces

7. Expected due date: _____

8. Any difficulty at time of birth: _____ Yes _____ No If yes, please explain: _____

HEALTH OF PATIENT

- 1. Serious illness or deformities: _____ Yes _____ No If yes, please explain: _____

- 2. Serious accidents or injuries: _____ Yes _____ No If yes, please explain: _____

- 3. Any surgeries: _____ Yes _____ No If yes, please explain: _____

- 4. History of high fever: _____ Yes _____ No If yes, please explain: _____

- 5. History of seizures: _____ Yes _____ No If yes, please explain: _____

- 6. Allergies: _____ Yes _____ No If yes, please explain: _____

- 7. Is the patient taking any medications now: _____ Yes _____ No If yes, please explain: _____

- 8. Eye problems: _____ Yes _____ No If yes, please explain: _____

- 9. Was the patient bottle fed: _____ Yes _____ No
- 10. Does the patient take a bottle at this time: _____ Yes _____ No
- 11. Does the patient have frequent colds, sore throats, or earaches: _____ Yes _____ No
- 12. Has the patient's tonsils and/or adenoids been removed: _____ Yes _____ No

DEVELOPMENTAL HISTORY OF PATIENT (please circle yes or no and give age)

- 1. Holds head up: Y N Age: _____
- 2. Rolls over: Y N Age: _____
- 3. Sits alone: Y N Age: _____
- 4. Crawls: Y N Age: _____
- 5. Pulls to stand: Y N Age: _____
- 6. Stands alone: Y N Age: _____
- 7. Walks alone: Y N Age: _____
- 8. Run: Y N Age: _____
- 9. Grasps toys: Y N Age: _____
- 10. Puts things hand-to-hand: Y N Age: _____
- 11. Feeds self with fingers: Y N Age: _____
- 12. Feeds self with spoon: Y N Age: _____
- 13. Scribbles: Y N Age: _____

Describe any positions or movements that the patient likes or dislikes: _____

Describe any specific concerns you have about the patient or his/her development: _____

SPEECH HISTORY:

- 1. Does the patient have a speech impairment: _____ Yes _____ No
- 2. Does the patient have a hearing impairment: _____ Yes _____ No
- 3. Is the patient responsive to sounds or voice: _____ Yes _____ No
- 4. When did the patient begin to use single words: _____ months
- 5. When did the patient begin to use sentences: _____ months
- 6. Does the patient speak in: _____ words _____ phrases _____ complete sentences
- 7. When were you first concerned about a speech or hearing impairment: _____

- 8. Can the patient be understood by parent/guardian: _____ Yes _____ No
- 9. Do other family members have a speech or hearing impairment: _____ Yes _____ No
If yes, who? _____
- 10. Has the patient ever had more words than he/she has now: _____ Yes _____ No
- 11. Has the patient's hearing ever been tested: _____ Yes _____ No
If yes, when? _____ Pass? _____ Yes _____ No

Are there any problems with the following:

Tongue	_____	Throat	_____	Drooling	_____
Jaws	_____	Teeth	_____	Writing	_____
Palate	_____	Chewing	_____	Reading	_____
Nasal Passages	_____	Swallowing	_____		

Can the patient do the following without help:

Dress/Undress:	_____ Yes	_____ No	Bathe:	_____ Yes	_____ No
Clothes fasteners:	_____ Yes	_____ No	Brush teeth:	_____ Yes	_____ No
Go to bathroom:	_____ Yes	_____ No	Feed self:	_____ Yes	_____ No

OTHER IMPORTANT INFORMATION/CONCERNS:

What specific skills or areas are you concerned with regarding school readiness? _____

Does the patient have difficulty adapting to change: _____Yes _____No If yes, please explain:_____

What areas do you consider as strengths for the patient:_____

Does the patient need to be reminded or redirected to complete tasks: _____Yes _____No

If yes, please explain:_____

Does the patient have daily responsibilities or chores at home: _____Yes _____No If yes, please explain:_____

How long can the patient stay on task:_____

Can the patient complete a task in a timely manner: _____Yes _____No

Are reminders or time limits required: _____Yes _____No

Can the patient express his/her needs adequately: _____Yes _____No

If yes, is it done verbally, by pointing, etc:_____

What types of activities/interests does the patient like:_____

Does the patient avoid any activities: _____Yes _____No If yes, please explain:_____

BEHAVIOR (please circle the statements that describe the patient):

Happy	Nervous	Prefers to play alone	Destructive
Temper tantrums	Sensitive	Nightmares	Stubborn
Cries easily	Thumb sucks	Overactive	Easily managed
Slow learner	Shy	Outgoing	Unusual fears
Jealous	Sad	Demands excessive	Affectionate
Friendly	Attention	Has NO playmates	Plays well with others
Energetic	Likes school	Has playmates	Overly talkative

ADDITIONAL INFORMATION MAY BE ADDED TO THE BACK OF THIS FORM.

Signature

Relationship to child

Date



PERMISSION TO BILL

Insurance Billing

I, _____, give In-Sync Pediatric Therapy Center, LLC permission to **bill my insurance** for occupational, physical, and/or speech therapy services. I understand that insurance must be billed and Medicaid benefits can be utilized.

Personal Billing

I acknowledge that if there is a lapse of coverage due to losing Medicaid benefits, or private insurance coverage, In-Sync Pediatric Therapy Center, LLC will **bill me directly** for any dates of service that are not covered by my insurance.

The amount to be billed to the responsible party will be the current Medicaid rates for evaluation and/or therapy treatment.

Signature

Date



CANCELLATION POLICY

Welcome to our office. We appreciate the opportunity to work with you and your family. Our office is dedicated to high quality patient care. To maintain our high standards, we believe that it is important we communicate our policies to you. Please take a moment to read and become familiar with this policy. Should you have any questions, we are happy to help. By presenting this policy in advance, we can avoid any surprises or misunderstandings. We appreciate your time and cooperation.

Our clinic strives to provide the best therapy services possible. In order to ensure optimal use of valuable therapy time, please discuss schedule changes at the end of your appointment with your child's therapist. We understand occasional changes are necessary due to illness, vacations, etc. Please call our office within 24 hours of a scheduled appointment if you need to cancel or reschedule that appointment. This allows for clients to reschedule into additional openings therapists may have. For Monday appointments, our office appreciates being notified no later than Friday afternoon. This will allow other patients in need of care to be accommodated. It is unfair to both the other patients and therapists to not allow for others to schedule into the open time slots. You may call the clinic at 479-474-6444 or contact your therapist directly by phone or text. Our therapists are always available to you.

- You are expected to be on time for your scheduled appointment and arrive on time to pick up your child. This is to ensure that parents are present so that the therapist can collaborate with the parent/guardian(s) and allows other children's sessions to begin on time.
- Late fees and charges will be implemented if you are consistently late to your appointment time or are late to pick up your child. *Note: Insurance companies DO NOT reimburse for late fees; this is the responsibility of the parent/guardian(s).*
- Effective January 1, 2017, In-Sync will be enforcing a \$25.00 charge for no-shows without any contact to explain your absence. Three consecutive no-shows require your child to be placed on a hold status until the issue of missed appointments is resolved. If a resolution is not made within 5 business days, your child will lose his/her therapy time slot and be placed on a waiting list.
- We require an 80% attendance rate and will need to take the patient off the therapist's schedule if it is not adhered to. Late attendance will also affect this rate. *Note: We will be tracking visit numbers and as a courtesy, we will notify you when your percentage drops below the required 80%.*

We are happy to work out scheduling problems with you. Please let us know if you are experiencing a problem with your current schedule. If therapy needs to be canceled for a couple of weeks, such as an extended trip, we will hold your therapy spot for up to three weeks. We will then have to place you on a waiting list and will fit you back in the schedule as soon as we can.

I hereby understand the above cancellation policy and agree to abide by it.

Parent or Legal Guardian Signature

Date



Acknowledgment of Receipt Of Privacy Practices

I, _____ have received a copy of In-Sync Pediatric Therapy Center, LLC's Notice of Privacy Practices with an effective date of August 1, 2007.

Name of Patient: _____

Address of Patient: _____

Signature: _____

Date: _____

Name of Witness: _____

Signature of Witness: _____ Date: _____



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

***Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include crowns, fillings, teeth cleaning services, etc.

***Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your dental services.

***Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may

disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public.

We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

*The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

*The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.

* The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.

* The right to request an amendment to your PROTECTED HEALTH INFORMATION.

*The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.

*The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

Privacy Official
Jocelyn Mitchell
In-Sync Pediatric Therapy, LLC
1109 Fayetteville Road
Van Buren, AR. 72956
479-474-6444

For more information about HIPAA or to file a complaint:

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Ave., S.W.
Washington, D.C. 20201
877-696-6775



SICK POLICY

In order to prevent infection, we are asking that no sick individuals enter our clinic. This includes your children and their siblings, caregivers, and/or yourself. Your child will not be able to obtain the maximum benefit from therapy when they feel sick. Please keep your child or any of the above mentioned people home if they have the following:

- Fever (must be fever free for 24 hours without medication, before returning)
- Yellow or green discharge from the nose
- Persistent cough
- Sore throat
- Vomiting
- Upset stomach/nausea
- Lice
- Diarrhea
- Impetigo/infantigo or staph infection
- Rash
- Conjunctivitis (pink eye)
- Any other infectious diseases (flu, chicken pox, mumps, etc.)
- We must have a release signed by your physician to resume therapy after **ANY** surgery your child may have had.

Our efforts are to prevent the spread of disease to children with low immunity systems. Also, as therapists, if we get sick, is not only affects your child, but many other adults, children, and our own children as well.

**If your child is sick and you need to cancel, please call BEFORE your scheduled appointment time.*

You may contact the clinic or therapist about a possible make up session. We will do our best to accommodate! We appreciate your understanding and cautiousness in this matter.



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