CARROUSEL THERAPY CENTER CORPORATION

PATIENT INTAKE FORM

PT/OT/ST/PSYCHIATRIC

PATIENT INFORMATION **DATE:**

Child's Name:_____ Gender: M☐ or F☐
Last First MI

Date Of Birth: _____-_____-_____ SS#_____-_____-_____

ADDRESS:_____CITY:_____STATE_____ZIP:_____

REFERRING SOURCE

Physician Name_____
Last First MI

Phone: (___)_____FAX: (___)_____

PARENT/LEGAL GUARDIAN

Name:_____
Last First MI
RELATION TO CHILD:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

DAY PHONE: (___)_____EVE PHONE: (___)_____CELL: (___)_____
E-MAIL:_____

INSURANCE **MUST FILL THIS OUT

PRIMARY INSURANCE:_____**Phone:**_____
Policy Number:_____ **Group:**_____
Policy Holder:_____ ***Relation to Patient:**_____
Policy Holder's Date of Birth_____-_____-_____
Policy Holder's SS#_____-_____-_____ **Employer:**_____

REASON FOR REFERRAL/DIAGNOSIS_____
_____

SECONDARY INSURANCE:_____ **Phone:**_____
Policy Number:_____ **Group Number:**_____
Policy Holder:_____ ***Relation to Patient:**_____
Policy Holder's Date of Birth_____-_____-_____
Policy Holder's SS#_____-_____-_____ **Employer:**_____

CARROUSEL THERAPY CENTER CORPORATION

YOUR HEALTH CARE PROVIDER, INSURER, OR PLAN MAY REQUIRE A PHYSICIAN REFERRAL OR PRIOR AUTHORIZATION AND YOU MAY BE OBLIGATED FOR PARTIAL OR FULL PAYMENT FOR THERAPY SERVICES PROVIDED.

AUTHORIZATIONS and ACKNOWLEDGEMENTS

HIPPA: Notice of Privacy Practice

By signing this statement you are acknowledging that you have had the opportunity to receive HIPAA Notice of Privacy Practices:

PATIENT NAME
(Printed):_____

Signature:_____ Date:_____
Parent/Legal Guardian or self

INSURED OR AUTHORIZED PERSON'S SIGNATURE: I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby assign and request payment to be made directly to "Therapy," for services rendered to my child.

Signature:_____ Date:_____

"Signature on file" will automatically print on your claim form, allowing insurance to pay, directly.

Records Release:
PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I hereby authorize the release of any necessary information to process insurance claims, including medical and billing information, as well as to discuss the child's case information with other Therapists working within the building structure of _____ to/from, from/to the referring physician, Therapist Co-workers and insurance company.

Signature:_____ Date:_____

Scheduling (for first time appointments)
Please list all times your child would be available for their appointment/s. Some times are more difficult to schedule than others. It will assist us with scheduling your child quicker if you give us as many options as possible. We will do everything we can to work with you. Thank you for your assistance.

Please list all days and times your child is available:

_____

_____

CARROUSEL THERAPY CENTER CORPORATION

CHILD CASE HISTORY FORM

GENERAL INFORMATION:

CHILD'S NAME:	Date of Birth:	Age:
Person Providing the Information:	Today's Date:	Sex: M ☐ F ☐
Child's Address:	Referred By:	
Telephone Number: Cell Phone Number:	Physician:	
The family requests that results of this evaluation should be sent to: Name:_____ Name:_____ Address:_____ Address:_____ Please complete consent form to allow us to do this.		

Please describe reason for evaluation:

_____

_____

_____

Which services are you requesting?

- ☐ **Occupational Therapy**
- ☐ **Physical Therapy**
- ☐ **Speech Therapy**
- ☐ **Mental Health Counselor**
- ☐ **Psychosocial Rehabilitation Services**
- ☐ **Targeted Case Management**

Please list diagnosis, if any, who diagnosed, and when your child was diagnosed:

_____

_____

THERAPY PRECAUTIONS - Please be specific

Does your child have any food allergies? Please list.	Yes	No	
If your child has Down's Syndrome, has he/she been diagnosed with Atlantoaxial instability? Are there any movement restrictions?	☐	☐	
Are there any precautions not listed above that we should know about. Please describe.	☐	☐	

FAMILY HISTORY

Father's Name:	Age:	Occupation:
Mother's Name:	Age:	Occupation:
Is Client Adopted? YES ☐ NO ☐	If so, at what age and from where?	
Are Parent's (chose one): Living Together ☐	Separated ☐	Divorced ☐
Have there been any instances of the following in your immediate or extended family members: ☐ ADHD ☐ Learning Disability ☐ Communication Disorder ☐ Autism/PDD ☐ Hearing Loss		

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PREGNANCY AND BIRTH HISTORY

	Yes	No	Comments
1. Were there any illnesses, injuries, bleeding, or any complications during this pregnancy? Describe	☐	☐	
2. Was this pregnancy full-term? If not, please give gestational age and weight at time of delivery.	☐	☐	
3. Was labor and delivery normal?	☐	☐	
4. Did your child experience jaundice?	☐	☐	
5. Was there need for oxygen or respiratory assistance?	☐	☐	
6. Were there difficulties with feeding?	☐	☐	
7. Did your child bottle-feed or breast feed?	☐	☐	
8. Did your child have difficulties sucking?	☐	☐	
9. Number of siblings.			

MEDICAL HISTORY

13. Has your child had any of the following illnesses?	Yes	No	Comments
a. Meningitis	☐	☐	
b. Chicken Pox	☐	☐	
c. Seizures	☐	☐	
d. Frequent Ear infections	☐	☐	
e. Excessive vomiting or reflux.	☐	☐	
f. Cleft Palate	☐	☐	
g. Does your child have vision problems?	☐	☐	
h. Does your child use any adaptive equipment?	☐	☐	
i. Is your child on any medications? Please list.			
j. Please describe any pertinent medical conditions not mentioned above.			

GROWTH AND DEVELOPMENT

14. What age did your child:	COMMENTS:
a. Roll over from stomach to back?	
b. Roll from back to stomach?	
c. Sit independently?	
d. Walk	
e. Talk (words/sentences)	

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PATIENT SERVICE AGREEMENT

1. It is the patient/parents(s)/guardian responsibility to inform "Therapy" of any and all changes in insurance information, including group policy number, identification number, phone numbers, addresses, etc. as soon as possible. **Failure to do this could result in total patient responsibility for charges incurred.**

2. **Cancellation Policy –** We are committed to providing quality consistent services to our clients. Therapy will be most beneficial to your child with **consistent attendance**. It is also important that you **arrive on time** so that your child can benefit from a full session. Routine tardiness may result in billing that time directly to you. We understand that there will be unavoidable circumstances that may come up. In order for us to plan appropriately for staff, we require that parents call to cancel their appointment for illness or an unavoidable conflict as soon as possible. We reserve the right to charge a fee of $50.00 for missed unexcused absences and $25.00 for arriving 10 or more minutes late. Termination of services may occur following **three** sessions that were not cancelled ahead of time or following routine/regular cancellations. When possible, we will try to reschedule your appointment that week. There are many families that are waiting for services. We appreciate your cooperation with this.

3. For your convenience, "Therapy" allows parents/legal guardians or caregiver to leave the premises during their child's appointment. However, it is very important to be back on the premises 10 minutes before the patient's appointment is scheduled to end so the therapist can discuss treatment with the parent/legal guardian or caregiver. If "Therapy" notices chronic tardiness in picking up children, we will begin asking the parent/legal guardian or caregiver to stay during the patient's treatment. "Therapy" must have a cell phone number to reach you before leaving. By signing below, the parent also agrees to waive any and all responsibility that "Therapy" may have in ensuring the safety of your child after the therapy session time has finished. We are not a babysitting service and cannot be held responsible for your child's safety after his or her therapy session has finished.

4. Additionally, "Therapy" realizes the parent/legal guardian or caregiver's time is important, and it is our sincere intention to honor all appointment times. On occasion, a delay or emergency will occur. For this reason, we may need to delay or reschedule the patient's appointment. If this occurs, notification will be given as early as possible. To expedite this process, we ask the parent/legal guardian/caregiver to provide us with a daytime telephone number for notification purposes.

5. **Out of pocket policy: Insurance policies are contracts made between the patient and the insurance company. When insurance does not provide payment of therapy costs, payment of the bill is your responsibility. If for any reason treatment is denied by your insurance, we will charge for the usual and customary amount paid by your insurance company.**

   For your benefit, and to insure the highest level of coverage from your insurance company, we choose to participate in most insurance plans, which results in lower payments to the provider but lower costs to the patient.

   Both private insurers and the Federal Government prohibit waiving and/or reducing the co-payments. Due to binding contracts with each insurance company and industry wide standard ethics, we are required to collect all co-payments and deductibles that are due by your specific policy. We are obligated to be in compliance with these standards.

   In case of hardships: The parent/legal guardian must provide written notification to "Therapy" detailing the circumstances warranting a need for a reduced fee. Completion of a personal financial statement form is required to be completed for our consideration. If granted, reduced fees are provided for a period of six months. Prior to the end of the six months, if circumstances have not changed, parents may request an extension in writing.

CARROUSEL THERAPY CENTER CORPORATION

Waiver: Your child is receiving Occupational, Physical, and or Speech Therapy services from board certified Therapists. The plan of care is a collaboration of the Therapist and the family. To ensure that your child will improve, all recommendations need to be followed as given. Even if this occurs, every child responds in their own way. We cannot guarantee that the Parents/Caregivers predetermined outcome for their child will be achieved. By signing below, you agree to these statements and conditions presented above.

Patient Service Agreement between below "Parent/Legal Guardian" and "Therapy"

_____ _____

NAME OF PATIENT DOB

_____ _____

SIGNATURE: PARENT/LEGAL GUARDIAN Date

_____

PRINT NAME

CARROUSEL THERAPY CENTER CORPORATION

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I,_____(the term "**I**" refers to the Parent/Legal Guardian of child) understand that as part of my healthcare, "**Therapy**," originates and maintains paper and/or electronic records describing "my" (the term "**my**" refers to parent and/or child) health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care of treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contributes to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a ***Notice of Information Practices*** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I understand that "**Therapy**," is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that "**Therapy**," reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should "**Therapy**," change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or if I agree e-mail).

I wish to have the following restrictions to the use or disclose of my health information:

_____

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax and/or e-mail.

I fully understand and accept the terms of this consent.

_____ _____

Parent/legal Guardian's Signature Date

FOR OFFICE USE ONLY

☐ Consent received by _____on_____

☐ Consent refused by patient, and treatment refused as permitted.

☐ Consent added to the patient's medical record on _____

CARROUSEL THERAPY CENTER CORPORATION

HIPPA Release Form

I_____, parent/guardian of patient

_____

give permission to "**CARROUSEL THERAPY CENTER**" and all employees to discuss and/or receive medical information including medical records concerning any and all aspects of patient's previous healthcare by a doctor, physical, occupational or speech therapist, or other medical professional. This release is required to obtain medical information according to the privacy rule detailed in HIPPA (The Health Insurance Portability and Accountability Act of 1996).

_____

Patient Name:

_____

Patient Date of Birth:

_____

Patient's Social Security:

_____

Parent/Guardian's Name (Printed):

_____

Parent/Guardian's Signature:

_____

Date: _____

CARROUSEL THERAPY CENTER CORPORATION

Credit Card Agreement

All parents and guardians are responsible for paying their child's co pay and deductibles, set by their Insurance Company. These fees are nonnegotiable. Unless otherwise specified, we will collect these fees every session. We have made this process easier by accepting Visa card, Master card, American Express card, and Discover card. By signing below it is agreed that your credit card number will remain on file and "_____" will charge that credit card only in the event that your child attends his or her therapy session. A receipt will be provided to you for all charges applied.

We hope this makes everything easier for you to keep track of your fees.

Thank you,

_____, Title _____

_____ _____

Parent/Guardian Signature Date

_____ _____

Credit Card # MC/Visa/American/Discover Expiration Date