Let me begin by saying “thank you” for choosing Allied Therapy and Consulting Services as your child’s therapy provider. We hope to make this a smooth transition into therapy. In order for this to happen, we must ask you, as the parent or guardian, to help us complete all the necessary paperwork. Enclosed you will find a Client Information Sheet, a Consent for Release of Information, a Release of Photographs/Video, Home Health & Cancellation Policy, the HIPAA Information Sheet, Insurance & Financial Responsibility sheet, in addition to multiple Medical & Social History Form. All of these forms must be completed, signed and returned along with a copy of your insurance card before any services will begin. Completion of these forms will allow our team to provide your child with the best care possible. Allow me to explain each of these forms. The Client Information Sheet not only gives our office general information about your child, but it also determines other possible pay sources for your child. We do our best to point families in the direction that their child could most benefit.

The Medical History Form gives our therapists the information needed to make an accurate assessment of your child. This also enables the therapist to be prepared when meeting your child for the first time.

The Consent of Release of Information allows our group to request and receive evaluations completed about your child by other facilities, in addition to prescriptions and referrals needed from your child’s physician to provide therapy.

Allied Therapy and Consulting Services continues to support and conduct research for the benefit of therapy for children. The Release of Photographs/Video form allows your child to participate within this process, for example reviewing tapes of progress in skills. You would be informed in advance if this occurred.

Due to the increasing cost of fuel and the basic living expenses, we have adopted a Home Health and Cancellation Policy to consolidate drive time for our therapists and ensure consistent therapy for our clients.

The last forms that must be signed and returned are the HIPAA Information Sheet and the Insurance & Financial Responsibility Sheet. This is simply a HIPAA notice that describes how medical information about you may be used, disclosed and how you, as the parent or guardian may receive access to this information. The Responsibility sheet documents that you are aware of our policies regarding payment of services.

After reviewing this information and completing it, you may mail it to P.O. Box 333, Ward, Arkansas 72176, or you may fax it to 501-843-2270. Upon receipt of your paperwork, you will be notified regarding the next step needed to establish services. If you have further questions or concerns, please feel free to contact Stephanie Ingram, our Intake Coordinator, at 501-941-5630 ext 205.

Thanks for your time and considerations on these important matters!
Client Information Sheet
2013

Child’s Name: ______________________________________________________

DOB: __________ Race: __________ Gender: M / F

SS #: __________________________ Medicaid #: _________________________

Primary Language: ________________________________________________

Primary Diagnosis: ________________________________________________

Secondary: _________________________________________________________

Address __________________________________________________________

City ___________________________ Zip __________________________

County: ___________________________ State: ____________________________

E-mail Address: ______________________________________________________

Home Phone #: _______________ Cell Phone #: __________________________

Once therapy is established, would you feel comfortable receiving “texted” information, in regards to cancellations or schedule changes?

Yes or No

Mother’s Name _______________________________ DOB: __________

SS# ___________________________ Employer _________________________

WK# ______________________________
Child’s Name: ____________________________________________

Father’s Name ___________________________ DOB: __________

SS# ___________________________ Employer ____________________________

WK# ____________________________

Emergency Contact: ____________________________

Phone #: ____________________________

Physician: ____________________________ Phone #: __________________

Fax #: ____________________________

Primary Insurance: ____________________________

Phone #: ____________________________

Policyholder's Name: ____________________________

Policy #: ____________________________ Group #: ____________________________

Group Name: ____________________________

Assignment of Benefits

I authorize payment of medical benefits be paid directly for services rendered.

Authorization for Treatment

I authorize treatment be given as ordered by my physician.

__________________________________________
Signature of Parent or Guardian

_________________________
Date
Insurance & Financial Responsibility

As a client of Allied Therapy and Consulting Services, P.A., you are required to sign a financial responsibility and authorization for treatment form.

As a courtesy to our families, we will contact your insurance company to verify benefits. Please read your insurance handbook and be aware of what coverage and benefits your insurance company offers. When in doubt, contact your insurance carrier directly for clarification. You will be responsible for payment of care not covered by your insurance plan. Please include a copy of the insurance card when returning information packet.

Co-Pays and Deductibles

It is Allied’s policy that parents be prepared to pay their required co-payment at the time services are rendered. If deductibles must be met, then payment for services will be expected until complete.

Further questions or concerns, may be directed to our Billing Department, at 501-941-5630, Ext. 201.

Please sign and return with your information packet, documenting that you are aware of the above policies and understand what is expected.

Child’s Name:__________________________________________

Parent/Guardian Signature:_______________________________  Date:_______
Home Health & Cancellation Policy

Last minute cancellations due to unforeseen medical problems are understandable, however, frequent cancellations or no shows are not. Because Allied Therapy is one of the few that continues to provide services to families with medically fragile children, within their home environments, the demands on our therapists’ schedules are quite difficult. We must ask our families to take these circumstances into consideration when scheduling and communicating with our office. Unfortunately, due to these circumstances, we typically have a waiting list. It is unfair to children, which also deserve to receive therapy, denied a consistent visit when a current client has multiple cancellations. Therefore, if your child is given a weekly therapy time and during any 3-month period we experience 50% cancellations or unplanned absences, you will be notified that your child will be placed onto our waiting list or our cancellation list. The cancellation list is a list for clients that are contacted on a weekly basis as our therapists have cancellations and offered a possible therapy time for that week.

I have read and understand this policy.

__________________________________________
Child’s Name

__________________________________________  ____________
Parent/Guardian Signature   Date
Consent for Release of Information

Client’s Name: __________________________ Date of Birth: ______

I hereby give authorization to Allied Therapy and Consulting Services to release or receive information regarding needs and services for my child from the following:

Physician: ______________________________________________________

Hospital: ______________________________________________________

Therapist: _____________________________________________________

School: _______________________________________________________

Other: _________________________________________________________

**Medical information to another Physician or Insurance Company to assist in treatment or claim processing or to others identified by the parent or guardian.

_______________________________________________________________
Printed Name of Parent or Guardian

_______________________________________________________________
Signature of Parent or Guardian Date
Release of Photographs/Videos

I, ____________________________ give Allied Therapy and Consulting Services, permission to photograph and/or record my child, ____________________________ to release for use in research, to show progression of his/her skills, or to the therapist’s discretion. Additional confirmation will be made if photographs are to be used for promotional purposes.

Signature______________________________Date_________
Medical & Social/Behavior History Form
Please complete the best to your knowledge

Name: ___________________________ Date: __________

Date of Birth: ___________ Diagnosis: __________________________

Sex: ________ Primary Care Physician: __________________________

Specialists (Physicians):________________________________________

________________________

Child lives with:

Mother ____ Father ____ Stepmother ____ Stepfather ____ Guardian ____

If guardian, please list name and relationship to child: ______________________

Other people in the household:
Name Age Relationship

________________________________________

________________________________________

________________________________________

________________________________________

Pregnancy: Normal:____________________ Illnesses:____________________

Complications:___________________________________________________

List any unusual conditions or concerns during pregnancy or delivery (premature, cesarean, complications after birth):
Child’s Name: ____________________________________________

**Birth History:** Length of Pregnancy (Typical length of pregnancy is 40 weeks)

__________________________________________

Child’s Birth Weight:___________ APGAR Scores:_____________________

Complications:__________________________________________

Hearing Screening:  Yes  No  Dates:___________ Results:______________

Vision Screening:  Yes  No  Dates:___________ Results:______________

Feeding/Swallow Testing:  Yes  No  Dates:_____________

Results:__________________________________________

Physical Examination:  Yes  No  Dates:___________ Results:______________

**Medical Information:** Please circle “yes” or “no” to the following.
If “yes”, please list additional information on the following line.

Allergies: Yes  No
________________________________________________________________________

Seizures: Yes  No
________________________________________________________________________

Behavior Issues: Yes  No
________________________________________________________________________

Sensory Issues: Yes  No
________________________________________________________________________

Cerebral Palsy: Yes  No
________________________________________________________________________

Autism: Yes  No
Child’s Name: ______________________________________

Surgical Procedures Completed

Yes

No

____________________________________________________________________________

Hospitalizations

Yes

No

____________________________________________________________________________

Current Medications & Allergies: ________________________________

____________________________________________________________________________

Current Equipment (AFOs, walker, communication devices, etc.): ______________

____________________________________________________________________________

**Developmental:** At what age did your child begin to or complete the following:

<table>
<thead>
<tr>
<th>Item</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sat alone:</td>
<td></td>
</tr>
<tr>
<td>Crawled:</td>
<td></td>
</tr>
<tr>
<td>Walked alone:</td>
<td></td>
</tr>
<tr>
<td>Made sounds:</td>
<td></td>
</tr>
<tr>
<td>Single words:</td>
<td></td>
</tr>
<tr>
<td>Phrases:</td>
<td></td>
</tr>
<tr>
<td>Understood by others:</td>
<td></td>
</tr>
<tr>
<td>Toilet trained:</td>
<td></td>
</tr>
<tr>
<td>Dressed self:</td>
<td></td>
</tr>
<tr>
<td>Fed self:</td>
<td></td>
</tr>
</tbody>
</table>

**Educational History**

Programs before public school:

Preschool: ______________________ HIPPY: ______________________

Headstart: ______________________ Early Intervention: _____________
Other: ________________________________

Child’s Name: ________________________________

Public or Private School Attended or Attending:

Name of School ________________________________ Grade ______

Type of Classroom ________________________________

Has the child ever:

Repeated a grade(s): Yes ______ No ______ If so, which one(s) ______

Been in a special education class or received remedial help? If yes, explain:

________________________________________________________________________

Has there ever been behavior concerns? ________________________________

________________________________________________________________________

Current Areas of Concern: ________________________________

________________________________________________________________________

Social/Behavior History

How often do the following behaviors occur? (O = Often, S= Sometimes, N=Never)

<table>
<thead>
<tr>
<th>Behavior</th>
<th>O</th>
<th>S</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inattentiveness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyperactivity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nervousness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Withdrawn</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excitability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor Self Image</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obsessive/Compulsive</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other behaviors: ____________________________
Child’s Name: ____________________________________________

Describe how the child gets along with parents and other family members:

___________________________________________________________________________

___________________________________________________________________________

Does the child go to bed easily?  Yes  No

Does the child wake easily in the morning?  Yes  No

What time does the child go to bed?  ________________________________

What time does the child get up in the morning?  ________________________________

Is sleep sound?  Yes  No  Is sleep restless?  Yes  No

List any significant events/changes in the home (death in the family, divorce, move, family discord):

___________________________________________________________________________

___________________________________________________________________________

Circle Services being requested:

Physical Therapy  Occupational Therapy

Speech Therapy  Developmental Therapy

Past/Current Therapy Received:

<table>
<thead>
<tr>
<th>Therapy or Evaluation</th>
<th>Facility/Therapist</th>
<th>Frequency</th>
<th>Last Date of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developmental</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Child’s Name: __________________________________________

**History of Speech/Language Difficulties**

Has your child previously been assessed for speech/language concerns?  Yes  No

What are your concerns with your child’s language? ________________________________

Has your child received any prior speech/language therapy?  Yes  No

If “yes”, where?__________________________ For how long?__________________________

Focus of the treatment?: ________________________________

Results of treatment?: ________________________________

Did any other family member have speech/language problems?  Yes  No

If “yes” please list the relationship to the child and the nature of the problem: ________

Has your child experienced ear infections?  Circle:

- Never
- Occasionally
- Frequently

Has your child ever had P.E. tubes?  Yes  No

Has your child’s hearing ever been tested?  Yes  No

Results:__________________________

Do you feel your child hears normally?  Yes  No

Explain:__________________________

Does your child experience difficulties with the following:

- Understanding spoken language  Yes  No
- Using words or gestures to communicate  Yes  No
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Producing speech sounds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Following directions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child’s Name: ______________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excessive drooling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chewing or swallowing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Picky eater</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stuttering</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reading</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you answered “yes” on any of the questions above, please explain: ______________________

__________________________________________________________

__________________________________________________________

Information Completed by: ________________________________
Physical, Occupational, Speech & Developmental Therapy

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.*

**Effective: April 14, 2003**

If you have any questions about this notice, please contact the Allied Therapy and Consulting Service, P.A. Privacy Officer at 501-941-5630.

**Who will follow this notice:**

This notice describes the practices of Allied Therapy and Consulting Services, P.A. and that of:

- All Contracted, Sub-contracted and Salaried Employees
- Any persons who may provide services to Allied Therapy for the administration of the needs of our clients, including, but not limited to, lawyers, accountants, auditors, and data processors.
- Any physician or other person who assists Allied Therapy with the review of the quality of therapy services provided to our clients.
- Any individual that our clients may request to contact Allied Therapy about medical history or concerning therapies that have been received.

We understand that medical information about our clients and their health is personal. We are committed to protecting medical information about them including their medical history and payments for services (referred to as “Protected Health Information” or “PHI”). The records that are created are used to provide correct and accurate services to our clients and to comply with certain legal requirements.

**Law to requires us:**

- Make sure that all PHI is kept private;
- Give our clients this notice of our legal duties and privacy practices with respect to all PHI; and
- Follow the terms of the notice that is currently in effect

**How we may use and disclose Medical Information about our clients:**

Allied Therapy and Consulting Services may use and disclose your PHI to determine services that may be provided by:

- Reviewing all information and documentation necessary to determine eligibility and services needed.
- To review for accuracy of processing and to recover any loss of funding.
- To review the quality of the services provided.
- To conduct fraud and abuse detection in investigations.
- To respond to inquiries and complaints.
- When required to do so by federal, state or local law.
- When necessary to prevent serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- We may use PHI for the purpose of providing quality therapy or other services to our clients.
If a client provides us permission to use or disclose medical information about them, you may revoke that permission, in writing, at any time and we will not longer use or disclose such PHI for the reasons covered by written authorization. Understand that Allied Therapy will be unable to take back any disclosures that have occurred with your permission, and that we are required to retain our records of the care that we provided to our clients.

**Clients’ rights regarding personal medical information:**
The following are the rights regarding medical information that Allied Therapy maintains:
Right to inspect and obtain a copy. Clients have the right to inspect and obtain a copy of PHI that may be used by Allied Therapy to make decisions about services. This includes evaluations and progress notes.

Right to request restrictions:
Clients have the right to request a restriction or limitation on the PHI we use or disclose about our clients for treatment, payment or health care services. Clients also have the right to request a limit on the PHI we disclose about clients to someone who is involved in the client’s care or the payment for the client’s care, like a family member or friend.

Right to request confidential communications:
Clients have the right to request that we communicate with them about medical matters in a certain way or at a certain location. For example, a client may request that we only contact them at home or by mail. To request confidential communications, a client must make the request in writing to Allied Therapy. We will not ask the reason for such requests. We will accommodate all reasonable requests. All requests must be specify how or where the client is to be contacted.

Changes to this notice:
We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about our clients as well as any information we receive in the future.

Complaints:
If a client believes their privacy rights have been violated, you may file a complaint with Allied Therapy or with the Secretary of the Department of Health and Human Services. To file a complaint with Allied, contact the Privacy Officer at Allied Therapy and Consulting Services, P.A., P.O. Box 333 Ward, Arkansas, 72176. All complaints must be submitted in writing.

**You will not be penalized for filing a complaint. Effective Date: April 14, 2003**

Signature _________________________________________ Date __________