NEW CLIENT PACKET

Physical, Occupational, and Speech Therapy

5532 JFK Boulevard
North Little Rock, AR 72116
(501) 588-3211

1500 Wilson Loop Rd, P.O. Box 333
Ward, AR 72176
(501) 941-5630

6705 Alma Hwy.
Alma, AR, 72921
(479) 222-3802

Thank you for choosing Allied Therapy and Consulting Services as your child's therapy provider. Our goal is to make this a smooth process for you and your child. In order for this to happen, a parent or legal guardian must complete all of the following necessary paperwork. Enclosed you will find a Client Information Sheet, a Consent for Release of Information, a Release of Photographs/Video, a Home Health & Cancellation Policy, a HIPAA Information Sheet, an Insurance & Financial Responsibility sheet, and Medical & Social History forms. All of the forms must be completed, signed, and returned to us. We will also need a copy of your current health insurance card(s) and/or your Medicaid information if applicable. If your child has had a previous therapy evaluation within the last year, please bring a copy and turn it in with this packet. Your cooperation with this will allow our team to provide your child with the best care as fast as possible.

The Client Information Sheet not only gives our clinic general information about your child, but it also determines other possible pay sources that may be available to your child that you may be unaware of. 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 clinic to request and receive evaluations completed on your child by other facilities, in addition to prescriptions and referrals needed from your child's physician in order to begin therapy in a timely manner and in order for us to provide the most effective therapy for your child.

The Release of Photographs/Video form allows us to possibly take photos and/or videos of your child if needed for records and certain research that may be needed for your child's therapies. We may also use photos of your child for advertising on our social media sites and magazine publications. If any of these occur, you will be notified beforehand.

The Home Health and Cancellation Policy form is needed in order to consolidate drive time for our therapists and ensure consistent therapy for our clients.

The HIPAA Information Sheet and the Insurance & Financial Responsibility Sheets are needed in order to describe how medical information about your child may be used, disclosed, and how 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 we receive this paperwork, you will be notified regarding the next step needed to establish therapy services for your child. Please allow us 1-2 weeks to notify you. This allows us time to contact your PCP and gather all of the necessary information to begin your services. If you have further questions or concerns, please feel free to contact Anjolic Smith, our Intake Coordinator at the North Little Rock clinic at 501-588-3211 or Paula Vance, our Intake Coordinator at the Ward clinic at 501-941-5630.

You may scan and email this information to: schedules@allied-therapy.com, fax it to: NLR 501-353-2599 or Ward 501-843-2270, or Mail or Drop it off to the clinic address at the top of the page that is closest to you.

Again, thank you for choosing Allied Therapy and Consulting Services as your therapy provider!

ALLIED THERAPY

Client Information Sheet

Childs Name:_____

Home Phone:_____ Cell Phone:_____

Email Address:_____

Address:_____ City:_____

State:_____ County:_____ Zip-code:_____

Date of Birth:_____ RACE: _____ Gender: M / F

Social Security #: _____ Medicaid #:_____

Primary Language:_____ Secondary Language:_____

Primary Diagnosis:_____

Secondary Diagnosis:_____

Once therapy is established, would you feel comfortable receiving texts via cell phone regarding schedule changes, cancellations, etc? **Y** or **N**

If Yes, what number would you prefer for us to send the text to? _____

If No, what number is best to call in these situations? _____

CHILDS NAME:_____

Family Information:

Mother's Name _____

Date of Birth_____ Social Security # _____

Employer_____ Emp Phone#_____

Father's Name _____

Date of Birth_____ Social Security # _____

Employer_____ Emp Phone# _____

Emergency Contact: _____

Emergency Contact Phone# _____

Physician / Insurance Information:

Physician: _____

Physician Phone#: _____

Primary Insurance: _____

Insurance Phone#: _____

Policy Holder's Name: _____ Policy Acct #_____

Group Name: _____ Group# _____

Secondary Insurance: _____

Insurance Phone#: _____

Policy Holder's Name: _____ Policy Acct #_____

Group Name: _____ Group# _____

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ASSIGNMENT OF BENEFITS

I, _____, authorize payment of medical benefits to be paid directly to Allied Therapy and Consulting Services, P.A. for services rendered to: _____.
Childs Name

I, _____, authorize treatment be given to: _____ as ordered by my physician.
Childs Name

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. We will contact your insurance company to verify benefits. It would be beneficial for you if you read your insurance handbook and were aware of what coverage and benefits your insurance offers. When in doubt, contact your insurance carrier directly for clarification. You will be responsible for payment of services not covered by your insurance plan.

Please include a copy of your insurance card when you return this information packet.

CO-PAYS & DEDUCTIBLES

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

Further billing questions or concerns may be directed to our Billing Department at 501-912-6409.

Please verify that you understand and will abide by the above policies by signing below:

Childs Name: _____

Parent/Guardian's Signature:
_____Date:_____

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CANCELLATION & HOME HEALTH POLICY

Last minute cancellations due to certain unforeseen circumstances are understandable. Frequent cancellations or not showing up with proper notification will not be tolerated. In order to ensure the best attendance for your child please communicate the best times that you have available for therapy. Allied Therapy is one of the few companies that continues to provide services to families with medically fragile children, within their home environments. At times this makes scheduling difficult for many of our therapists. Because of this, we must ask our families to take this into consideration by letting our scheduling department know when your child will not be attending therapy. The more in advance you let us know, the more time we will have to adjust schedules for our therapists. This will also allow us to fit in families that are on our waiting list. We see it unfair when children who deserve and desperately need therapy be denied visits when a current client has continuous cancellations. Therefore, if your child is given a weekly therapy time and during any three month period we experience 50% cancellations or unplanned absences, you will be notified that your child will be placed on 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.

By signing below you are acknowledging that you have read and understand the above policy.

Childs Name:_____ Date:_____

Parent/Guardian's Signature_____

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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(s): _____

Hospital(s): _____

Therapist(s): _____

School(s): _____

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/Guardian:_____

Signature of Parent/Guardian:_____ Date_____

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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:_____

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Medical, Social, & Behavior History Form

Child's Name: _____ Date_____

Date of Birth: _____ Sex: M or F

Diagnosis: _____

Primary Care Physician: _____

Physician Specialists: _____

_____

Child Lives with: Mother_____ Father_____ Stepmother_____ Stepfather_____ Guardian_____

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

_____

Other individuals that regularly stay in the home:

Name Age Relationship

_____

_____

_____

_____

Child's Name: _____

Pregnancy Experience during birth with child:

Normal? _____ Illness?_____

Complications?_____

List any unusual conditions or concerns during pregnancy or delivery (premature, cesarean, complications after birth, etc): _____

_____

Birth History

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

_____

Child's Birth Weight:_____ APGAR Scores:_____

Hearing Screening: Yes or No Dates:_____ Results:_____

Vision Screening: Yes or No Dates:_____ Results: _____

Feeding / Swallow Testing: Yes or No Dates:_____

Results:_____

Physical Examination: Yes or 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 or No

_____

Seizures: Yes or No

_____

Behavior Issues: Yes or No

_____

Sensory Issues: Yes or No

_____

Child's Name: _____

Cerebral Palsy: Yes or No

_____

Autism: Yes or No

_____

Surgical Procedures Completed: Yes or No

_____

Hospitalizations: Yes or No

_____

Current Medications:

_____

Current Allergies:

_____

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

_____

Developmental:	At what age did your child begin to or complete the following?
Sat Alone	
Crawled	
Walked Alone	
Made Sounds	
Single Words	
Phrases	
Understood by others	
Toilet trained	
Dressed self	
Fed self	

Child's Name: _____

Educational History

Programs Before Public School:

Preschool:_____ HIPPY:_____

Headstart:_____ Early Intervention:_____

Other:_____

Public or Private School Attended or Attending:

Name of School _____ Grade:_____

Type of Classroom: _____

Repeated a grade(s): Yes or No If Yes, what grade? _____

Reason(s) for repeated grade: _____

Been in a special education class or received remedial help? Yes or No

If yes, explain:_____

Has there ever been behavior concerns? Yes or No

If yes, explain:_____

Current Areas of Concern:_____

Social/Behavior History

Please circle how often the following behaviors occur? (O = Often, S= Sometimes, N=Never)

Inattentiveness	O	S	N	Frustration	O	S	N
Hyperactivity	O	S	N	Strong Fears	O	S	N
Nervousness	O	S	N	Depressed	O	S	N
Withdrawn	O	S	N	Aggressive	O	S	N
Excitability	O	S	N	Excessive Shyness	O	S	N
Poor Self Image	O	S	N	Lack of Confidence	O	S	N
Obsessive/Compulsive	O	S	N				

Other behaviors not listed above: _____

_____

Child's Name: _____

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

_____

_____

_____

Does the child go to bed easily? Yes or No

Does the child wake easily in the morning? Yes or No

What time does the child go to bed? _____

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

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

List any significant events/changes in the home (death in the family, divorce, move, family discord) that may affect the child's sleep, behavior, etc:

_____

_____

_____

_____

Child's Name: _____

History of Speech/Language Difficulties

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

What are your concerns (if any) with your child's language skills?_____

_____

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

If yes, for how long?_____

Focus of the treatment?:_____

Results of treatment?:_____

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

If yes, please list the relationship to the child and the nature of the problem(s):_____

_____

Has your child experienced ear infections? Circle One: Never Occasionally Frequently

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

Has your child's hearing ever been tested? Yes or No Results:_____

Do you feel you child hears normally? Yes or No

If no, explain:_____

Does your child experience difficulties with the following? Circle Yes or No

Understanding Spoken Language	Yes	No
Using words or gestures to communicate	Yes	No
Producing speech sounds	Yes	No
Following directions	Yes	No
Excessive drooling	Yes	No
Chewing or Swallowing	Yes	No
Picky Eater	Yes	No
Stuttering	Yes	No
Reading	Yes	No

Child's Name: _____

If you circled Yes on the graph on the previous page, please explain why:_____

_____

_____

_____

_____

Please circle the services being requested:

Physical Therapy Occupational Therapy

Speech Therapy Developmental Therapy

Past/Current Therapy Received

Therapy / Evaluation	Facility / Therapist	Frequency	Last Date of Service
Physical Therapy			
Occupational Therapy			
Speech Therapy			
Developmental Therapy			

*If previous therapies were received, please include a copy of the therapy evaluation given within the last year when you turn in this packet.

Information Completed by:

Print Name: _____

Signature: _____ Date:_____

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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 501-588-3211.

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 requires us to:
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 inquires 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_____