NLR - NEW SCHROTH CLIENT PACKET

Physical, Occupational, and Speech Therapy

5532 JFK Boulevard
North Little Rock, AR 72116
(501) 588-3211
(501) 353-2599 FAX

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. <u>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.</u>

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 our Intake Coordinator, Robin McGowan at our North Little Rock clinic at (501)588-3211.

You may scan and email this information to: rmcgowan@allied-therapy.com, fax it to (501)353-2599, mail it to us at 5532 JFK Boulevard, North Little Rock, AR 72116 or simply drop it off at the clinic during business hours.

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

Client Information Sheet

Client Name:____Date: ___________________________

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? ____

CLIENT's NAME:____

Family Information: (if client is a minor or under legal guardianship)

Mother's Name ____Date of Birth______________

Social Security # _______________________________ Occupation________________________

Employer____________________________________ Emp Phone#________________________

Father's Name ____Date of Birth_______________

Social Security # _______________________________ Occupation_________________________

Employer____________________________________ Emp Phone# ________________________

Emergency Contact: _______________________________________Relationship:___________________

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 # ______________________

Physical, Occupational, and Speech Therapy

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

1500 Wilson Loop Rd
Ward, AR 72176
(501) 941-5630

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: ___________________________.
Client Name

I, ______________________________, authorize treatment be given to: ___________________________ as ordered by my physician.
Client Name

Client Signature:____Date:_________________
(Parent/Guardian if applicable)

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 clients or 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:

Client Name: ____

Client Signature:____Date:____________________
(Parent/Guardian if applicable)

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CANCELLATION 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 needs please communicate the best times that you have available for therapy. Allied Therapy is one of the few companies that provides services to a variety of locations for clients from birth through adulthood. At times this makes scheduling difficult for many of our therapists. Because of this, we must ask our clients to take this into consideration by letting our scheduling department know when you will not be attending therapy. The more advance notice you provide, the more time we will have to adjust schedules for our therapists. This will also allow us to fit in clients that are on our waiting list. We see it unfair when clients who deserve and desperately need therapy be denied visits when a current client has continuous cancellations. Therefore, if you provided a weekly therapy time and during any three month period we experience 50% cancellations or unplanned absences, you will be notified that you 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.

Client Name: ____

Client Signature:____Date:___________________
(Parent/Guardian if applicable)

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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 client or parent/guardian.

Printed Name of Client:____
(Parent/Guardian if applicable)

Signature of Client:____ Date____________________
(Parent/Guardian if applicable)

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Release of Photographs/Videos

I, ____ give Allied Therapy and Consulting Services, permission to photograph and/or record me to release for use in research, to show progression of skills, or to the therapist's discretion.

If client is a minor or under legal guardianship:

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.

Client Name: ____

Client Signature:____Date:____________________
(Parent/Guardian if applicable)

Client In-Take Information

*All information provided will remain confidential

PERSONAL INFORMATION

Client Name_______________________________________ Gender: M / F DOB______________

Age________________________ Height__________________________ Weight______________________

Address______________________________ City_______________________ State_______ Zip_________

Cell______________________________ Email____

Referred By____

VISIT INFORMATION

Reason for Visit____

Condition is: Getting Worse ⌋ Getting Better ⌋ Constant ⌋ Comes & Goes ⌋

Medical Diagnosis (if provided)____

When did this start & under what circumstances?____

What do you think caused this?____

What makes it better?____

What makes it worse?____

Have you seen a healthcare provider for this issue?____

Has treatment by any healthcare provider been effective?___________________________________

Do I have permission to contact your physician regarding your issue? YES / NO

If yes, who is your primary care provider?____

PAIN - If pain is part of the reason for your visit, please describe

Site / Location____

Constant / Intermittent________________________________ Gradual / Sudden_______________________

Character (what does the pain feel like?)____

Radiation (does it shoot elsewhere?)____

Association (what else is happening along with the pain?)________________________________

Time / Duration____

Exacerbating / Relieving Factors____

Severity (how high is the pain?)____

LIFESTYLE

Tobacco: Do you use any of the following tobacco products? If yes, how long & at what frequency?

⌋ Cigarettes________________________________ ⌋

Cigars___________________________________

⌋ Vape____________________________________ ⌋

Dip_____________________________________

⌋ Other Tobacco____

Has your use of tobacco been different in the past? If yes, describe____________________________________

Did your use of tobacco change recently? If yes, describe____

Caffeine: Do you drink caffeinated beverages? If so, what quantity & frequency?

⌋ Coffee____________________________________ ⌋ Tea_____________________________________

⌋ Sodas____________________________________ ⌋ Power Drinks_____________________________

⌋ Other Caffeine____

Has your caffeine intake been different in your past? If yes, describe___________________________________

Did your caffeine intake change recently? If yes, describe____

Alcohol: Do you drink any alcoholic beverages? If so, what quantity & frequency?

⌋ Beer______________________________________ ⌋

Wine_____________________________________

⌋ Hard Liquor_________________________________ ⌋ Other Alcohol_____________________________

Has your alcohol intake been different in your past? If yes, describe___________________________________

Did your alcohol intake change recently? If yes, describe____

Sleep: On average, how many hours do you sleep?_________________________Bedtime_________________

Do you usually sleep through the night? ⌋ Yes ⌋ No ⌋ Varies

Is your sleep usually ⌋ Light ⌋ Deep ⌋ Varies

Do you fall asleep easily? ⌋ Yes ⌋ No

Do you wake up easily? ⌋ Yes ⌋ No

Has your sleep rhythm been different in your past? If yes, describe____________________________________

Did your sleep rhythm change recently? If yes, describe____

Diet: Do you follow a particular diet?____

What is your appetite like? ⌋ Low ⌋ High ⌋ Constant ⌋ Variable

How often do you eat processed sugar?____

⌡ Dessert_________________________________ ⌡ Soda / Sweet Tea_______________________

⌡ Other processed sugar____

How often do you have meat?____

Has your diet been different in your past? If yes, describe______________________________________

Did your diet change recently? If yes, describe____

Water: How much water do you have per day?____

Weight: Do you monitor your weight regularly?____

How easy is it for you to put on weight? ⌡ Easy ⌡ Medium ⌡ Hard

How easy is it for you to lose weight? ⌡ Easy ⌡ Medium ⌡ Hard

Has your weight been different in the past? If yes, describe___________________________________

Did your weight change recently? If yes, describe____

Skin:

How do you react to the sun? ⌡ Tan easily ⌡ Burn easily ⌡ Somewhere in between

Check all that apply regarding your skin:

⌡ Thin ⌡ Dry ⌡ Freckles / Moles ⌡ Flush easily ⌡ Soft ⌡ Smooth

Exercise:

Describe your exercise routine: (movement type & frequency)_________________________________

____

Has your exercise routine been different in the past? If so, describe____________________________

Did your exercise routine change recently? If so, describe_____________________________________

Emotional Profile: ⌡ Tend toward anxiety ⌡ Tends toward impatience ⌡ Steady & Gentle

Stamina: ⌡ Tend to over-exert ⌡ Over-exerts in competitive situations ⌡ Tend to under-exert

Memory: ⌡ Learn & forget quickly ⌡ Learn quickly, forget slowly ⌡ Learn & forget slowly

Thoughts: ⌡ Verbal imagery ⌡ Visual imagery ⌡ Feelings & emotions

Climate Preference: ⌡ Warm ⌡ Cool ⌡ Change of seasons

SOCIAL

Residence: Where do you live?____

Co-Residents: Who lives with you?____

Occupation: What is your job?____

How long have you been at your current job?____

What is your work schedule like?____

Hobbies: Do you have any hobbies? If yes, list hobbies & frequency of participation_____________________

____

Clubs: Do you belong to any clubs? If yes, list clubs & frequency of attendance_________________________

____

MEDICAL HISTORY

Have you ever been diagnosed with any of the following conditions? If so, When?

⌡ Asthma_____________________________ ⌡ Irritable Bowel Syndrome_________________________

⌡ COPD / Emphysema__________________ ⌡ Constipation____________________________________

⌡ Osteoporosis________________________ ⌡ Inflammatory Bowel Disease_______________________

⌡ Diabetes____________________________ ⌡ Reflux / Stomach Ulcer___________________________

⌡ Heart Disease_______________________ ⌡ Thyroid Disease_________________________________

⌡ High Blood Pressure__________________ ⌡ Obesity____

⌡ Other____

Are you currently being treated by a healthcare provider? If yes, describe______________________________

____

Do you have any family members who suffered from any of the above? If yes, describe___________________

____

____

____

Immunity: What is your immune system like? ⌡ Low Resistance ⌡ Medium Resistance ⌡ High Resistance

Allergies: Do you have any allergies / sensitivities? ⌋ Medicine ⌋ Food ⌋ Environmental

If yes, describe____

Medication: List all medications & supplements (use another page if necessary)

Medication / Supplement	Prescribed / Taken for	When do you take it?

Mental Health: Have you ever had any mental health diagnoses? If yes, describe_______________________

____

____

____

Are you currently being treated by a healthcare provider? If yes, describe_______________________

____

MUSCULOSKELETAL HISTORY

Injuries: List any injuries (i.e. sprains, tears, broken bones, etc.) & treatment provided (including surgeries)

Injury	Treatment	Date

For Clients with Scoliosis:

When were you first diagnosed with scoliosis?____

Please describe your curve pattern: (i.e. vertebral segments involved, degree of curvature, etc.)

____

____

Have you received prior treatment for your scoliosis? If yes, please describe (i.e. PT, chiropractic, etc.)

____

Have you utilized bracing for your scoliosis? If yes, please describe (i.e. how long, type of brace, etc.)

____

____

Have you been diagnosed with any other spinal conditions not already listed above (i.e. spondylolisthesis, degenerative disc disease, herniated disc, etc.) ____

____

Do you have copies of your most current x-rays (paper print off is fine), radiological report, and orthopedic physician notes from your most recent visit?

⌋ YES - Please provide this information with this packet or bring with you to your evaluation

⌋ NO, but I will obtain these and bring to my evaluation

⌋ NO, please request them from my treating physician (be sure to indicate physician on release form above)

*Please note that it can often take physician's offices longer to provide records to us than directly to the patient. We are certainly willing to request these documents for you; however, please know that these documents are important for your therapist to have in order to properly classify your curve pattern for treatment planning, and our delay in receipt of this information could delay your treatment start date.

Is there any other health information that you would like to share in order to best help you?

____

____

____

____

All information contained herein is confidential unless otherwise authorized by the client.

By signing below I acknowledge that I have stated all medical conditions that I am aware of and will give an update of any changes in my health status as soon as I am made aware of the condition. I understand that these services are in no way to take the place of a doctor's care. I understand that any acts of indiscretion will be cause for immediate termination of services.

____ ____________________

Client Signature Date

(Parent/Guardian if applicable)

____

Printed name of Client or Parent/Guardian

Patient Rights & Responsibilities:

***Please Note: that as Allied Therapy's population involves clients under the age of 18, as well as, clients under the legal guardianship of other individuals; these listed rights & responsibilities are intended for the inclusion of the parent(s) / guardian(s) responsible for the client.**

Patient Rights

1. **Patients** have the right to receive considerate and respectful care, and to be made comfortable. You have the right to respect for your cultural, psychosocial, spiritual, and personal values, beliefs and preferences.

2. **Patients** have the right to to be provided with appropriate privacy.

3. **Patients** have the right to confidential treatment of all communications and records pertaining to your treatment / plan of care (as indicated by Allied Therapy's HIPAA policy and release of information policy).

4. **Patients** have the right, to the degree known, to have complete information concerning their diagnosis evaluation, treatment, and prognosis as related to the services provided.

5. **Patients** have the right change healthcare providers.

6. **Patients** have the right to make decisions regarding your plan of care, and receive as much information about any proposed treatment as you may need in order to give informed consent, or to refuse a course of treatment.

7. **Patients** have the right to reasonable continuity of care, and to know in advance the time and location of appointments, as well as, the identity of the person(s) providing the care.

By signing below I consent to understanding my patient rights as outlined by this document.

____ ______________________

Client Signature Date
(Parent/Guardian if applicable)

____

Printed name of Client or Parent/Guardian

Patient Responsibilities

***Please Note: if the client is under the age of 18 or under the legal guardianship of another individual; the parent(s) / guardian(s) are accountable for these responsibilities**

1. **Patients** have the responsibility to provide complete and accurate information, including full name, address, home telephone number, date of birth, Social Security number, insurance carrier and employer, when it is required; as well as, to provide updated information as changes occur.

2. **Patients** have the responsibility to provide accurate and complete information about current and past illnesses, medications, and other matters pertaining to their health.

3. **Patients** have the responsibility to follow the treatment plan and home programming recommended by their healthcare provider or to express concerns regarding their ability to comply. You are responsible for reporting whether you clearly understand your treatment plan and what is expected of you. You are expected to ask questions when you do not understand information or instructions.

4. **Patients** are responsible for their actions and outcomes if they refuse treatment or do not follow the healthcare provider's instructions (including following the treatment plan and home programming).

5. **Patients** have the responsibility to arrive as scheduled for appointments and to cancel with at least 24 hours advance notice for appointments they cannot keep.

6. **Patients** have the responsibility to become informed of the scope of basic services offered, the costs, and the necessity for medical insurance, and to actively seek clarification of any aspect of participation in your care (including cost) that is not understood.

7. **Patients** have the responsibility to accept financial responsibility for all services rendered by Allied Therapy as promptly as possible.

8. **Patients** have the responsibility of being considerate to the rights of others by treating Allied Therapy staff, other clients and visitors with courtesy and respect.

By signing below I consent to understanding my patient responsibilities as outlined by this document. If I am the parent/guardian of a client, I consent to understanding that I am accountable for upholding these responsibilities. I also consent to my understanding that failure to uphold these responsibilities will affect the ability of Allied Therapy to provide quality and appropriate care, which could lead to discharge from services and required notification to my primary care physician.

____ __________________
Client Signature Date
(Parent/Guardian if applicable)

____
Printed name of Client or Parent/Guardian