Associated Therapies, Inc.

Pediatric Occupational, Physical, and Speech Therapies
1456 B McLendon Drive, Decatur, GA-30033
Tel: (404) 728-9766 • Fax: (404) 728-9166

<table>
<tr><th colspan="8">PATIENT INFORMATION</th></tr>
<tr><td colspan="3">Child's Last Name: First:
Middle:</td><td colspan="2">Birth Date:</td><td>Age:</td><td colspan="2">Sex:</td></tr>
<tr><td colspan="8">Parent/Guardian Name:</td></tr>
<tr><td colspan="4">Street Address:</td><td colspan="4">City, State Zip Code:</td></tr>
<tr><td colspan="2">Home Phone:</td><td colspan="2">Mobile Phone:</td><td colspan="4">Email:</td></tr>
<tr><td colspan="8">Physician (s): (if group, please provide practice name and name of primary physician)</td></tr>
<tr><td colspan="8">Physician's address:</td></tr>
<tr><td colspan="3">Physician's Phone:</td><td colspan="5">Physician's Fax:</td></tr>
<tr><td colspan="8">Specialists:</td></tr>
<tr><td colspan="8">Referred by:</td></tr>
<tr><th colspan="8">PRIMARY INSURANCE INFORMATION</th></tr>
<tr><td colspan="8">(PLEASE PROVIDE A FRONT AND BACK COPY OF YOUR INSURANCE CARD)</td></tr>
<tr><td colspan="4">Primary Insurance Company:</td><td colspan="4">Type: (PPO, POS, HMO)</td></tr>
<tr><td>Primary Insured Name:</td><td>Birth date:</td><td colspan="4">Address (if different)</td><td colspan="2">Home Phone:</td></tr>
<tr><td>Member ID:</td><td>Group:</td><td colspan="6">Employer:</td></tr>
<tr><td colspan="8">Insurance Carrier's Mailing Address:</td></tr>
<tr><th colspan="8">SECONDARY INSURANCE INFORMATION</th></tr>
<tr><td colspan="8">(PLEASE PROVIDE A FRONT AND BACK COPY OF YOUR INSURANCE CARD)</td></tr>
<tr><td colspan="4">Secondary Insurance Company:</td><td colspan="4">Type: (PPO, POS, HMO)</td></tr>
<tr><td>Secondary Insured Name:</td><td>Birth date:</td><td colspan="4">Address (if different)</td><td colspan="2">Home Phone:</td></tr>
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PATIENT INFORMATION				
Child's Name:	Age:	Grade:	Birth Date:	Sex:
Person Completing this form:		Relationship to child		
BACKGROUND INFORMATION				
Mother's Name	Mother's Occupation	Mother's Email Address:		
Home Phone:	Cell Phone:	Work Phone:		
Father's Name:	Father's occupation	Father's email:		
Street address				
Referred by:				
Describe your child's home environment (please add all the member's and caregiver's of the house hold)				
Does anyone in your family have speech, developmental, neurological, or hearing problems? If yes please explain:				
Describe your concerns regarding your child's development:				
Has there been a traumatic life event that your child has experienced? If yes, please explain				
Has your child been referred by a professional? (teacher, physician)				
Has your child been given a diagnosis? Yes No what is the diagnosis?				
Does your child receive special services? If yes, please explain:				
Has your child's vision been tested? If yes, by whom and when? Please explain the results of the best				
Has your child's hearing been tested? If yes, by whom and when? Please explain the results of the test				
Does your child wear any assistive devices?				
__Hearing Aids	___ Splints	___Orthotic Inserts	___Augmentative devices	_____Protective Head gear

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PARENTAL AND BIRTH HISORY

Mother's age when child was born	length of the pregnancy in weeks	Birth weight

Were there any complications during the pregnancy or birth? If yes, please explain:

Type of delivery:

Please explain

Were there any problems or complications immediately following the birth or during the few weeks of your infant's life?
□ Jaundice □ feeding □ swallowing □ hospitalizations □ seizures □ other
Please explain:

How long was the infant's stay in the hospital following birth?

Did the child come home from the hospital with you? Yes No

Breast fed? □ Yes □ No How long?

Bottle Feb? □ Yes □ No How long?

Pacifier? □ Yes □ No How Long?

Developmental History

At what age did the following developmental milestones occur?

______Held head up	_____ Followed objects with eyes	_____ rolled over from back to stomach
______Sat up unsupported	______ Crawled	_____stood alone
_____ Walked alone	______ fed self with spoon	_____ Dressed self
______ Toiled trained	______ Used fork	_____ Dressed Self

At what age did the following speech/language milestone occur?

______ babbled or cooed	______ said first word	______ Begin to use two-word phrases
______ begin to use sentences	______ followed simple directions	______ pointed to objects

How your child express his/her self? (please circle one) Sentences Phrases one or two words sounds gestures other:	How many words are in your child's vocabulary? _______

Does your child have any feeding/swallowing issues? If yes, please explain:

What type of foods does your child prefer? Any food refused?

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CURRENT FUNCTIONING

On a scale of 1 to 4 how well does your child function in the following areas? Circle one) depending on the age of your child, it may be completely appropriate for them to be dependent in many areas of functioning
1= Completely dependent on others. Needs lots of help or cues
2= Requires adult assistance for 50% of the tasks or 50% of the time.
3= Requires very little,, but some adult assistance
4= Completely independent. No difficulties in this area

Area					
Dressing upper body	1	2	3	4	Not applicable
Taking off clothing	1	2	3	4	Not applicable
Putting on shoes/socks	1	2	3	4	Not applicable
Putting on pants	1	2	3	4	Not applicable
Buttoning	1	2	3	4	Not applicable
Zipping	1	2	3	4	Not applicable
Eating (breast or bottle)	1	2	3	4	Not applicable
Eating (soft foods off spoons)	1	2	3	4	Not applicable
Eating (with fingers)	1	2	3	4	Not applicable
Eating (with utensils)	1	2	3	4	Not applicable
Playing with familiar peers	1	2	3	4	Not applicable
Playing with unfamiliar peers	1	2	3	4	Not applicable
Handwriting	1	2	3	4	Not applicable
Frustration tolerance	1	2	3	4	Not applicable
Sleeping Routine	1	2	3	4	Not applicable
Grooming (hair)	1	2	3	4	Not applicable
Grooming (bathing)	1	2	3	4	Not applicable
Grooming (teeth)	1	2	3	4	Not applicable
Maintaining attention to task	1	2	3	4	Not applicable
Entertaining self	1	2	3	4	Not applicable
Hand/eye coordination	1	2	3	4	Not applicable
Balance	1	2	3	4	Not applicable
Following verbal directions	1	2	3	4	Not applicable
Safety awareness	1	2	3	4	Not applicable
Cutting with scissors	1	2	3	4	Not applicable

Please list your child's strengths:

Please list your child's weakness:

What are your goals for therapy?

Please let us know your child's favorite things:

Food:	Snack:	Toy:
Drink:	Candy:	Game:
Toy:	TVshow/movie:	
Other favorite:		

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SENSORY

DOES YOUR CHILD DISLIKE OR IS OVERLY SENSITIVE TO ANY OF THE FOLLOWING:				
______GLUE	__SAND	__ NAILS TRIMMING	___WATER	_____GRASS
______MEAT	__SPINNING	__ TOOTH BRUSHING	___HAIR CUT	_____CLIMBING
______SWINGING		__LOUD NOISES	___CLOTHING TAGS	

DOES YOUR CHILD SEEK OUT:			
______ ROCKING	______ TWIRLING	_____ SPINNING	_______ROUGH HOUSE
______ JUMPING	______TEXTURES	_____ MOUTHING TOYS	

DOES YOU CHILD APPEAR:		
______INSENSITIVE TO PAIN	______DISTRACTED BY SOUND	______AGGRESSIVE
______CLUMSY	______EASILY FUSTRATED	
______ TO HAVE DIFFICULTY WITH PUZZLES / MANIPULATIVES		

PLEASE ADD ANY ADDITIONAL COMMENTS REGARDING THE ABOVE SENSORY ITEMS THAT WERE CHECKED, IF NEEDED: ____

Please be sure to include copies of following documents (if applicable): having these documents will assist your therapist in complete their assessment and getting a complete picture of your child.

- □ Current or most recent IEP/IFSP
- □ Prior speech, physical or occupational therapy evaluations
- □ Prior Psychological/Neurological Evaluations

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HIPAA PRIVACY PRACTICES

The purpose of this notice is to ensure that you (the patient) or your designated representative is made aware of your rights to ensure the privacy of your healthcare information. ATI retains the right to update this notice at any time. You will be notified of any changes and you will receive an updated copy from the office upon request.

1. **Privacy of Patient Information:** We have created a record of the services and treatment that you receive at Associated Therapies Inc. The privacy of your medical information is important to us and we are committed to protecting it. We are required by law to keep your medical information private and notify you of legal rights and privacy practices.

2. **Use and Disclosure of Patient Information:** Your child's therapy information will be used for treatment, payment and to communicate with other healthcare professions, payers, state and federal entities as well as law enforcement agencies in the interest of public safety or authorized educational institutions. HIPAA allows disclosure of this information to your designated contact which you may specify below:

Name of Designated/Authorized contact:	
Relationship to Patient:	
Authorization to disclose to or receive from (School or Healthcare Provider name):	

3. **Patient (or Designee's) Personal Communication:** You may communicate confidential information, including services, to me by the following means:

Mailing Address:	
Home Phone:	
Cell Phone:	
Email:	
Patient's Date of Birth:	

4. **Patient's Access to Medical Information:** You have the right to see and obtain a copy of your medical records at any time. You may request changes to your health information. If ATI does not agree with your changes, you must be allowed to insert a statement of disagreement into the patient's record. ATI is not required to agree with your changes. You may request the reason for any disclosures made on your behalf.

5. **Confidentiality of Patient Information:** Associated Therapies, Inc. will attempt in all cases to preserve the confidentiality of all oral and written medical information. This includes patient records, written information and electronic transmission of information to physicians, insurance companies, state and federal entities and law enforcement agencies in the interest of public safety. Associated Therapies, Inc. will not be held responsible in the event of natural disasters, theft or burglary of their physical and electronic property having taken reasonable precaution.

6. **How to file a Complaint**: You may file a complaint if you feel that your privacy rights have been violated. Please ask for a complaint form. ATI will not retaliate against you if you file a complaint. Complaints should be directed to the privacy officer.

7. Associated Therapies Inc Contact Information: You may contact the Practice Administrator at 404-728-9766

Patient's or Designee's Signature:______________________________ Date: __________________________________

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Billing Policy and Procedures

______1. We will bill your insurance as a courtesy to you. However, it is your responsibility to assist in the prompt receipt of payment from your insurance company and you are responsible for any unpaid charges, including co-payments/co-insurance.

______2. You must inform Associated Therapies, Inc. of any changes in your insurance, Medicaid or Babies Can't Wait coverage. Failure to notify us of changes will result in parent or legal guardian being responsible for payment.

______3. Parent or legal guardians are responsible for payment of services if insurance or secondary plan coverage does not cover a date of service or is terminated.

______4. Any invoice that is not paid within 30 days will receive a phone call or follow-up invoice with rebilling charge of $10.00. Any invoice not paid within 60 days will be turned over to collections.

______5. Continuation of therapy services is contingent upon timely payment of all bills

______6. Parent or guardian is also responsible for all the charges, if the child becomes ineligible for Medicaid, and he/she is not enrolled in Babies Can't Wait program, as well as non covered Medicaid services.

______7. If account is turned over to collections, an additional collection fee of 33% will be added to your total account.

______8. A copy of your Medicaid and/or Insurance card will need to be faxed/mailed to our office.

______9. If you need special assistance to pay your portion of therapy charges, please don't hesitate to call our office. We will be happy to develop a payment plan to assist you.

I understand and accept the billing policies and procedures listed above.

______________________________ ______________________________

Parent or Guardian Signature Date

I authorize payment of medical benefits and/or government benefits to Associated Therapies, Inc

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Parent or Guardian ____________________ Date ____________________

I authorize ATI to file a complaint to the insurance commissioner on my behalf.

Parent or Guardian ____________________ Date ____________________

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Fees and Payment Policies

Associated Therapies is here to provide your child with quality therapy services. We established fees that enable us to have the quality staff and facilities that are necessary to provide the care you expect. This explanation of our payment policies has been prepared so that you can help us maintain quality services. Like you, we are concerned about the cost of health care. Our payment policies are designed to enable us to reduce unnecessary collection costs, which would otherwise increase the cost to you.

Your responsibility for charges

You are ultimately responsible for the payment of charges for services you receive. If payment is to be made through insurance medical plan and we have agreed to accept assignment from that plan, then you are responsible for complying with any procedures required by that plan to enable us to receive payment on your behalf. To assure that your insurance or medical plan will provide covered benefits, you must let us know how you plan to provide payment for your visits. If you will be paying personally for the services or if you are responsible for deductible or co-payment, we expect payment at the time service is rendered. We accept check, cash, credit cards (visa, MasterCard and discover). If you are experiencing personal circumstances that will make the payment of our charges difficult for you, please ask to speak with our Business office personal.

PPOs, POS, and Government Plans

As a convenience to our patients, we participate with many PPOs, POS and government medical plans currently offered in this area. In order for our services to be covered under your plan, both parties must comply with the plan's requirements. It is your responsibility to know your plan's requirements for coverage. We will assist you with what we know; however, since these are "your" plans, we cannot make final determination regarding coverage; this must be done by your insurance company. Co-payments are to be presented at check in at the time of each visit.

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Patient Consent Form

I, ______________________________, hereby authorize Associated Therapies, Inc. to evaluate and treat ___________________________ for pediatric physical, speech or occupational therapy.

I understand that the client's protected health information may be used and disclosed to carry out treatment, payment or healthcare operations. For a more complete description of the potential uses and disclosures of the protected health information, please refer to the Notification of Privacy Practices issued on the first day of treatment. If you have misplaced your copy, please feel free to contact our office at 404-728-9766 and we will mail one to you. The Notice of Privacy Practice may change and you have the right to an updated copy. To receive a copy, please contact us at the above number. You have a right to review the Notice of Privacy Practices prior to signing this consent. If you have any questions, you may contact our privacy officer, Humera Savaja at 404-728-9766 ext 12

Please note that you have the right to request that Associated Therapies, Inc, restrict how your protected health information is used or disclosed to carry out treatment, payment or health care operations. It should be noted that the provider is not required to agree to requested restrictions; however, if the provider agrees to a requested restriction, the restriction is binding on the provider.

You have a right to revoke the consent in writing, except to the extent that the provider has taken action in reliance on it.

I give consent to leave a message on my voicemail system regarding my child and his/her care.

____ ___________________________

Parent or Legal Guardian Date

Notice of Privacy Practices

I, _________________________________, have been issued a copy of Associated Therapies, Inc. Notice of Privacy Practices. If there are any questions regarding this notice, I understand that I may contact the privacy officer, Humera Savaja at 404-728-9766 ext 12

____ ___________________________

Parent or Legal Guardian Date

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I understand that I have the right to review this office's Notice of Information Practices as displayed in the waiting room.

I have received a copy, and read the Notice of Information Practices posted in this office and understand its meaning. I understand that I have the right to request that this provider restrict how protected health information is used or disclosed to carry out treatment, payment or healthcare operations. And that the provider is not required to requested restrictions. I have the right to revoke the consent in writing except to the extent that the provider has taken action prior to the revocation. I understand that this authorization is voluntary.

____
Signature of patient or patient's representative Date

Printed name of patient's representative: __________________Relationship to Patient: __________________

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