Access Therapy
Physical Therapy Occupational Therapy Speech Therapy

Patient Information Form

Please Print Clearly

Patient Name:	DOB:
Street Address:	
City: State: Zip Code:	
Home Phone: Cell: Text OK?	
Referring Physician:	
Other Family Members Seen Here:	
BabyNet: Yes No	Early Interventionist/Service Coordinator:
INSURANCE INFORMATION	
Is this patient covered by Private Health Insurance?	Yes No
Name of Insurance Company:	Phone:
Subscriber Name:	Subscriber DOB:
Employer Name:	Subscriber SS #:
Group No:	
Patient's relationship to Subscriber:	
MEDICAID INFORMATION	
Is this patient covered by Medicaid?	Yes No
Medicaid #:	

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Access Therapies, Inc. I authorize Access Therapies or the insurance company to release any information needed to process claims.

Signature: ______________________________ Date: __________

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Release of Information/Consent Form

Patient Name: ______________________________ DOB: ______

Permission to Evaluate and Treat

I give permission for my child to undergo speech/language and feeding evaluations and to participate in treatment outlined in therapist's plan of care.

Parent Signature: ______________________________ Date: ________________

Release of Information

I give permission for Access Therapies, Inc. to receive and/or send medical records for my child ______________________________ to/from the following:

School District: ______________________________

Therapy Providers: ______________________________

MD Specialists: (Neurologist, ENT, Audiologist, Cleft Palate/Craniofacial Team, Geneticist, etc)

This authorization is given for the sole purpose of communication of patient information and will expire upon discharge unless written request is submitted.

Parent Signature: ______________________________ Date: ________________

Student/Volunteer Consent

I give permission for graduate students and/or volunteers to observe and/or participate in the treatment of my child for the purpose of education/training. I understand that the treating therapist will notify me in advance of such observations, and I may verbally decline them at that time.

Parent Signature: ______________________________ Date: ________________

Consent to Photograph/Video

I hereby authorize Access Therapies, Inc. to utilize photographs/videos of my child for the following purposes: (Check Applicable)

Advertising/Promotional Materials ______

Educational Purposes ______

Document Therapy Progress: ______

Other: ____________________

Parent Signature: ______________________________ Date: ________________

1500

HEALTH INSURANCE CLAIM FORM

(Sign + Date Box 12 + 13)

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single Married Other; Employed Full-Time Student Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES NO

b. AUTO ACCIDENT? YES NO PLACE (State)

c. OTHER ACCIDENT? YES NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED X DATE X

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED X

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a. | 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ___ . ___ 3. ___ . ___

2. ___ . ___ 4. ___ . ___

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

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Developmental/Medical /Social History

Patient Name: ____________________________ DOB: ______

Social History

Child lives with: Adoptive Parents ______ Birth Parents _______ One Parent ______

Foster Parent(s) ______ Parent and Step Parent ______ Grandparent ______

Other Children in the family/home:

Name	Age	Sex	Grade	Speech/Lang/Learning Problems?

Is there a language other than English spoken in the home? Yes ______ No ______

If Yes, which one? ____

Does the child speak the language? Yes ______ No ______

Does the child understand the language? Yes ______ No ______

Who speaks the language? ____

Which language does the child prefer to speak at home? ____________________________

Prenatal/Birth History

Did the mother receive **prenatal care** during pregnancy? Yes ______ No ______

List **complications** during **pregnancy/labor/delivery**: ____________________________

____

____

Was the baby born **prematurely**? Yes ______ No ______ If yes, length of gestation:__________

Birth Weight: ________________________________

Was the baby delivered by C-Section? Yes ______ No ______

If Yes, was the C-Section Planned? Yes ______ No ______

Was the child placed in **NICU?** Yes ______ No ______

If Yes, list reason and duration: ____

Medical History

Did the child have **feeding difficulties?** Yes ______ No ______

If Yes, explain: ____

____

____

Does the child have **allergies?** Yes ______ No ______

Does the child have **asthma or breathing difficulties?** Yes ______ No ______

Has the child had frequent **ear infections?** Yes ______ No ______

Has the child been **hospitalized** for any reason since birth? Yes ______ No ______

If yes, state age/reason ____

List **medications** below: Medication and Reason Prescribed:

1. ____
2. ____
3. ____
4. ____

List any **Specialists** the child sees or has seen:

____

____

____

Other Pertinent Medical Information: (i.e. hearing or vision difficulties, etc):

____

Developmental History

Normal **developmental milestones** were achieved? Yes ______ No ______

If no, list the age the child was able to:

Sit independently ________________ Crawl ________________

Stand ________________ Walk ________________

Say First Word ________________ Combine Words ________________

Feed Self ________________ Urine Trained ________________

Bowel Trained ________________ Dress Self ________________

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ATTENDANCE POLICY/PROCEDURES

Access Therapies is committed to providing quality treatment for children and their families. Our goal is to provide medically necessary natural and clinic-based therapy services in a professional and consistent manner. In order to maximize your child's potential in therapy, it is imperative that we adhere to our attendance policy. The following guidelines have been established to ensure the best services for your child:

I. Therapy appointment times will be arranged by your child's therapist. We will be as accommodating as possible when arranging treatment times.

II. Access Therapies understands that emergencies may arise that warrant appointment cancellations. It is our policy that your therapist make every effort to provide a timely cancellation when necessary and we ask that you make every effort to cancel your appointment **no less than 24 hours in advance.** This will enable the therapist to accommodate the need to reschedule. You may contact your therapist via their cell phone.

III. In order to maintain consistency in therapy services, the therapist will make every reasonable effort to reschedule missed appointments as their schedule allows.

IV. If your child fails to attend a scheduled appointment without reasonable effort being made to inform the therapist of a need to reschedule, Access Therapies will consider this a "No Show". The therapist will be available for fifteen minutes beyond the appointment time before declaring a "No Show".

V. If you "No Show" three times within an eight week period, your child will be discharged from Access Therapies. We are obligated to notify your EI and referring physician at that time. You will be placed on our waiting list and will be contacted when services can resume.

VI. If you "No Show" two appointments in a row and the therapist is unable to reach you to confirm future appointments, we will contact your EI, if appropriate, who will also attempt to communicate with you. If unsuccessful, Access Therapies may discharge your child from the program.

VII. Frequent cancellations that are not the result of **sickness or hospitalization** will also cause you to be discharged and placed on the waiting list.

VIII. We understand that circumstances may prevent you from being able to take advantage of the therapy services for which your child has been referred, or the services we provide are not meeting your family's needs. If this happens, please inform the therapist that you would like to discontinue services. You may also contact the Clinical Manager, Lisa Bishop, at 864-838-0768 to discuss how we may better serve your child and family.

Acknowledgement of Attendance Policy

I acknowledge receipt of Access Therapies Attendance Policy and understand the importance of consistent attendance in order to remain in the program and continue to receive therapy services.

_______________________________	_______________
Parent Signature	Date
_______________________________	_______________
Printed Name	Relationship
_______________________________	_______________
Therapist Signature	Date

Welcome to Access Therapy, speech and feeding therapy services!

Your child's assigned speech therapist is:

____

Your scheduled speech therapy appointment is:

____

If you are unable to keep your scheduled appointment, you **must** notify your therapist within 24 hours of the scheduled appointment. Please remember to follow our attendance policy in order to maintain your child's participation in therapy with our company.

You may direct any questions or concerns to:

Lisa Bishop, MCD,CCC-SLP, Supervisor

864-838-0768

LisaBishopSLP@hotmail.com

***Check out our facebook page and website for resources and announcements.**

www. AccessTherapiesOnline.com Facebook Page: "Access Therapies"