Client Information

Date:	DOB:	M: F:	Office Use: ID #

Clients Name:		Preferred Name:	
Address:	City:	State:	Zip:
Parent's/Guardian:			
Phone #:		Best way to contact:	
Email:		Adopted: y n Foster Parent: y n	
Emergency Contact:		Phone:	
Relationship to client:			
Referred by:			
Primary Physician:		Practice:	
Address:		O #:	F#:

Other Services (please indicate if received privately or with school system)	Receiving Currently (Name agency/therapist)	Received in Past (please indicate at what age and duration
Occupational Therapy		
Physical Therapy		
Speech Therapy		
Psychologist/Psychiatrist		
Neurologist		
Education Specialist		
Social Worker/counselor		
Applied Behavior Analysis (ABA)		
Other		

Medical Diagnoses:	
List Medications:	
Allergies/Special Diet:	
Any Visual Impairments?	Wears Glasses y n
Any Hearing Impairments?	Wears hearing aids y n
Birth History: Born at weeks gestation	Birth Weight:
Circle all that apply: Vaginal, Forceps, Vacuum C-section, Induced, other:	
Any Complications/Concerns?	
Was child premature? Y N In NICU or Received any Medical Treatment?	

Describe any major accidents, illnesses or hospitalizations:
Child's/Family's Primary Language:
Describe Child's Personality/Behavior at home:
Name of School/Preschool/Daycare: Grade:
Describe Child's Personality/Behavior in school:
Reason for Referral: What are your primary concerns about your child?
What are your goals for therapy?
What are your child's interest/strengths?
Please note the approximate age your child achieved the following skills

Rolling over	Sitting	Crawling	Cruising	Walking	Running	Jumping
Hopping	Skipping	Riding a tricycle	Riding a bike	First words	Talking	Other

Insurance Verification & Billing

Primary Insurance Information	
Insured Member's Name:	SS #:
Insured's Employer:	DOB:
Insurance Carrier:	Plan Type:
Member/Medicaid ID #:	Group #:
Insurance Mailing Address:	
Insurance Phone #:	

Secondary Insurance Information	
Insured Member's Name:	SS #:
Insured's Employer:	DOB:
Insurance Carrier:	Plan Type:
Member/Medicaid ID #:	Group #:
Insurance Mailing Address:	
Insurance Phone #:	

INFORMED CONSENT

I hereby authorize WE ACHIEVE PEDIATRIC THERAPY to contact my insurance carrier in order to determine eligibility for medical services. I understand that my insurance will be billed for services rendered by WE ACHIEVE PEDIATRIC THERAPY and its licensed therapists. I agree that if my insurance carrier issues a check in my name for reimbursement for services rendered by either the physician and/or facility, I will within five days of receipt of this check make payment in the amount of said check to the physician or facility.

The following also applies to the use of my insurance to cover the cost of services rendered:

Authorization To Release Medical Information For Billing

- I hereby authorize the release of any information regarding services by the Provider/Facility to process insurance claims.

Assignment Of Insurance Benefit

- I hereby authorize irrevocably assignment of payment for my benefits due me for the services rendered by the provider and the facility made directly to the provider and/or the facility.

Financial Responsibility

- I understand, regardless of my insurance benefits, that I am fully financially responsible for the fees for the services rendered. I agree to remit payments no later than 30 days from receipt of billing statement from WE ACHIEVE PEDIATRIC THERAPY or therapy may be discontinued.

I have read the above Informed Consent regarding insurance, understand its implications, and agree to abide.

Client's Name: _____

Parent/guardian's Name: (print) _____

Signature: _____Date: _____

CONSENT TO TREAT

The patient authorizes the Occupational Therapist to examine and treat the condition as he/she deems appropriate through the use of occupational therapy measures, and the patient gives the authorization for these procedures to be performed. The patient has the right to informed participation in decisions involving their own health care.

The patient will not hold the Occupational Therapist responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. The patient has the right to know who is responsible for authorizing and performing any and all treatment procedures. The patient shall not be subjected to any procedure without his/her voluntary, competent, and understanding consent or the consent of his legally authorized representative.

I acknowledge that my Occupational Therapist must be fully aware of my existing medical conditions. I have disclosed to my Occupational Therapist all of the medical conditions affecting me. It is my responsibility to update my therapist on my medical history.

I, the undersigned client or parent/guardian authorize the Occupational Therapist to: perform assessments, provide recommendations, resources and training as deemed necessary for client. I understand the results of the assessment and the recommendations will be discussed with me.

I have read the above consent to treat agreement, understand its implications, and agree to abide.

Client's Name: _____DOB: _____

Parent/Guardian's Name: (print) _____

Signature: _____

Date: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Please list all of the people and agencies you give consent for We Achieve Pediatric Therapy to release information to or be able to discuss your child's therapy with. Please add any names of family or person's who will be bringing or picking up from therapy sessions.

We will need to release written evaluations and treatment plans to the child's physician for treatment orders that are required for us to treat your child and to bill your insurance.

Therapist and Staff with We Achieve Pediatric Therapy, LLC will not release any information, either orally or written documents unless parent/guardian consent is given.

	Name	**Group/Agency**
Primary Physician: evaluations and treatment plan will be sent for physician's order (required for treatment)		
Other Physicians or specialist client is currently under care		
Daycare		
Preschool		
School		
Other Therapist: OT, PT, ST, ABA		
Relatives: (other than parent of guardians)		
Other: (please list persons that would be bringing or picking up from therapy)		

I authorize the names listed above to receive and distribute medically and educationally necessary information as needed to benefit the client. I understand this information may be shared by written report, phone conversation or transmitted by fax, email or text.

Client's Name: _____DOB: _____

Parent/Guardian's Name: (print) _____

Signature: _____

Date: _____

CREDIT CARD AUTHORIZATION

For ease of payment and benefit to our clients, we offer the service of storing a card on our secure portal payment system. We accept most major credit and debit cards as well as HSA cards. This card will be saved to your account so that copays and coinsurance can be collected after each therapy visit is rendered. A receipt will be emailed to the address on file as soon as charge is collected.

You have the right to cancel or add a card for billing purposes at any time by submitting the change in writing. It is your responsibility to update We Achieve with any new information. If a payment is denied by the credit card company, you will be contacted immediately. If 2 payments are missed client will be discharged from therapy until the account is current.

I authorize We Achieve Pediatric Therapy to charge my credit card on file after services are rendered. I understand my information will be saved and secure for future transactions on my account. This authorization will remain in effect until client is discharged from therapy and account has a zero balance.

Child's Name (print): _____

Parent/Guardian Name: (print) _____

Signature: _____ Date: _____

PRIVACY POLICY

Privacy Official:

Susan Cujas, Owner/Occupational Therapist
Phone: 336.940.2088
Email: susan@weachievepeds.com

I understand that I have the right to request a copy of the privacy policy of WE ACHIEVE PEDIATRIC THERAPY at any time from the above listed official. I understand the privacy policy and my rights regarding my protected health information.

Name: (print) _____

Signature: _____

Date: _____