APPLICATION FOR SERVICES

Client Information

NAME: _____ Marital Status: S M W D GENDER: M / F

Address: _____ DOB: _____ Age: _____

Emergency Contact: _____

Home Phone: (___) _____ Cell Phone:_____ Relationship:_____

Primary Care Physician: _____ Diagnosis:_____

Address: _____Phone: (___) _____

How did you hear about Reach for the Top?_____

Responsible Payer Information

Name(s): _____ Employer's Name:_____

Address:_____ Employer's Address:_____

Phone(s): (___)_____ Work Phone: (___)_____

Is your child receiving OT/PT/SP services elsewhere? Yes___ NO___ If yes, where? _____

Are those services being billed to your insurance? Yes___ NO___

Billing Information

□ NO INSURANCE

Primary Insurance: _____ Secondary Insurance:_____

INS POLICY #: _____ INS POLICY #_____

Policy Holder's Name: _____ Policy Holder's Name: _____

Policy Holder's DOB: _____ Policy Holder's DOB: _____

~Terms of Agreement~

REQUEST AND AUTHORIZATION FOR TREATMENT: I hereby request and authorize the medical director and/or the clinical or service-oriented staff of Reach for the Top administers all diagnostic and treatment procedures and/or services as is required for the above named client.

RELEASE OF INFORMATION: I further authorize the release of medical and other information necessary for completion of my claims, if any; in relationship to, insurance or compensation benefits.

_____ _____

(Adult Client/ Parent/ Legal Guardian) Date (Witness) Date

FINANCIAL RESPONSIBILITIY: I hereby assign into Reach for the Top Therapy Services,PLLC all health insurance benefits now due and to become due and payable to me by virtue of my treatment by said Agency. I hereby direct my insurance carriers to pay such benefits directly to such Agency in consideration of the service furnished and to be furnished by said Agency. I understand that I remain financially responsible to Reach 4, for changes not paid by my insurance carrier. Moreover, I understand that if I fail to meet any financial responsibilities as stated in these terms, I am responsible for the legal fees incurred by Agency in its effort to collect any money due to my account.

_____ _____

Responsible Payer/ Guarantor Date Witness Date

Reach for the Top
Therapy Services

EMERGENCY/MEDICAL INFORMATION

Services Requested:				
		Occupational Therapy		
		Physical Therapy		Speech Therapy

Clients Name: _____ DOB _____ SS#_____

Address _____
(Street) (City) (State) (Zip)

Parent (s)/Legal Guardian:_____

Home#_____ Work# _____Cell# _____

E-mail Address: _____

Diagnosis (if applicable):_____

Pertinent History/ Health Complications/Illness/Infections/Precautions/ Allergies:
_____
_____
_____
_____.

Primary Health Practitioner: _____

Address:_____
(Street) (City) (State) (Zip)

Phone # _____ Fax#:_____

Specialists (orthopedist, neurologist, ENT, ect): _____

---.

Preferred Hospital _____

If in case of emergency, I hereby authorized Reach for the Top Therapy Services (or their representative) to take whatever action is necessary for the above name individual.

Signature of Parent or Legal Guardian Date

In the event of an emergency, please contact:

Name	Relationship	Home Phone	Work or Cell Phone

Background Information

Reason for requesting services (be specific about any concerns): _____
_____
_____
_____.

Complications/illnesses/infections/stress during pregnancy? Y/N (describe)_____
_____
_____
_____.

Complications during labor and delivery? Y/N (describe)_____
_____
_____
_____.

Birth Order: _____ Birth Weight:_____ Premature/ Post mature/ Full Term (circle)

Problems feeding or respirations? Y/N (describe) _____
_____
_____
_____.

Developmental Milestones: Please note approximate age at which your child did the following:

SAT		FIRST WORD		MANAGED SNAPS	
BELLY CRAWLED		FIRST SENTENCE		MANAGED ZIPERS	
CRAWLED		UNDRESSED SELF		MANAGED BUTTONS	
CRUSED		DRESSED SELF		TIED SOES	
WALKED		TOUILET TRAINED		PERFERRED HAND L / R	

	CIRCLE ONE		DESCRIBE
ALLERGIES	YES	NO	
EAR INFECTION	YES	NO	
GLASSES	YES	NO	
HOSPITALIZATION	YES	NO	
INJURIES	YES	NO	
SEIZURES	YES	NO	
SURGERIES	YES	NO	

Medications (please list all): _____
_____
_____
_____.

Reach for the Top
Therapy Services

CO-PAYS / DEDUCTIBLES / CO-INSURANCE

As a contracted provider with most major insurance companies, Reach for the Top Therapy Services (REACH*4*) is required to comply with all policies and practices that govern our contractual agreements with insurers. As such, we want to ensure that you are aware of your responsibility in paying these costs as identified in your policy. **All co-pays must be paid at the time of each visit.** For your convenience, we accept some major credit cards (Master Card, Visa), debit cards, personal checks with appropriate identification, or cash. Any costs as a result of unmet deductibles, uncovered services or denied benefits will be billed to you. Your required signature on the application for services confirms your acceptance of financial responsibility. An outstanding balance of greater than 6 weeks may result in termination of services.

It is also critical to notify the office immediately with any changes in insurance coverage to avoid being billed for the full cost of services.

Thank you for your business and please understand that the quality services provided to your child are contingent of the revenues generated.

Warmest Regards,

Reach for the Top Therapy Services (PLLC)

Please sign if you have read and agree to the above terms and conditions:

Signature:_____ Date:_____

Reach for the Top
Therapy Services

CO-PAY AGREEMENT

Reach for the Top has requested your permission to bill your insurance company. This is an integral funding source in supporting Reach for the Top services. In agreement with this application, we must comply with the guidelines set forth in both your policy agreements and our contractual agreements with insurance companies. In order to do so, we are required to collect the co-pays required by your insurance company. Co-pays are due at time of service.

Please, notify the office manager of any changes to your insurance policy or financial situation as soon as possible. He or she will discuss possible adjustment(s) to the charges, if applicable.

Client's Name:_____ **DOB:**_____

Responsible Party for Payment:_____
(Name of Insurance) Subscriber/Parent/Legal Guardian)

Relationship to Client:_____

Address:_____
(Street) (City/State) (Zip Code)

Phone Number: _____ **Alt. Number:**_____

Co-Pay Amount: $_____ **(***Please, specify the amount identified by your policy).*

Notes/Comments:_____

I understand the above information. I confirm that all information above is accurate, and, I agree to pay in full the charges not covered by my insurance policy.

_____ _____ _____
Authorized Signature Date Witness Date

Reach for the Top: McConnell Center, 61 Locust Street, Dover, NH 03820
Phone Number: 603-740-3534 Fax Number: 603-740-3684

Reach for the Top
Therapy Services

Cancelation Policy

To The Families We Serve:

Reach for the Top Therapy Services (REACH *4)*, is pleased to partner with your family to support your child's development. Together we will ensure that your child will reach his/her full potential.

Our offices are continually growing to serve many children. Unfortunately, we are not able to meet the needs of all who seek our services. Therefore, there is a waiting list for services.

As a result, we will be strictly enforcing our cancellation policy. If your child is ill, clearly, he/she will not benefit from therapy, so we ask that you keep your child home. However, you will need to notify us the morning of the visit so we have the option of scheduling another child. If you know in advance that your child will miss his/her appointment, please call as soon as possible. If you need to cancel for any reason other than child illness or a family emergency, you must notify the office at least **48 hours** in advance of your child's appointment.

If you fail to show up for your appointment at any time and do not call, your child's future therapy slot will not be guaranteed. If you fail to show up for two appointments without calling the office, your child may be discharged. If you cancel three appointments in a two-month period, your child may be discharged as your child's success will not be achieved with inconsistent services. Of course, there are always extenuating circumstances, which we will take into account as long as you call and let us know.

We look forward to working with you and your family in supporting your child's success. Thank you for your cooperation.

Warmest Regards,

Kayleigh LaBrie

Office Manager

Reach for the Top
Therapy Services

CANCELLATION POLICY

PURPOSE:

A cancellation policy is necessary to help minimize client cancellations and "no shows"; in order to, maximize effective and efficient treatment for your child, family, and others.

POLICY STATEMENT:

In order to provide effective treatment programs, the client must make every effort to attend scheduled appointments.

Excused absences or cancellations should be called in to the appropriate office at least **48 hours** in advance. **Clients may be discharged from their therapy program following two (2) absences and/or "no shows" without prior notification.**

Thank you in advance for your cooperation.

_____ _____

Parent/Guardian Signature Witness Signature

_____ _____

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Reach for the Top
Therapy Services

CONSENT TO USE E-MAIL COMMUNICATION

1.All e-mail between the patient/client and/or legal representative(s) and Reach for the Top Services, PLLC ("Reach") that contain protected health information ("PHI") and that concern diagnosis and/or treatment will be made a part of the patient/client's medical record. Except as otherwise provided in this consent, the PHI contained in e-mail shall be subject to the terms and conditions of the Reach for the Top Privacy Practices.

2. If the patient/client and/or legal representative(s) sends an e-mail to a Reach staff member, he or she will endeavor to read the e-mail and promptly respond, if warranted. However, Reach does not provide assurance that the recipient of a particular e-mail will read the message and respond. Because Reach cannot assure patient/client and/or legal representative(s) that recipients receive, read, or respond to e-mail messages, **E-MAIL MUST NOT BE USED IN A MEDICAL EMERGENCY**.

3. If a patient/client and/or legal representative's e-mail requires or invites a response, and the recipient does not respond within a reasonable time, the sender is responsible for following up to determine whether the intended recipient received the e-mail and when a response can be expected.

4. Many employers do not "respect the privacy" of e-mail sent or received by employees over their business network. E-mail is routinely monitored by employers for security purposes. We advise our patients/clients and/or legal representatives **not** to use their employer's email system to transmit or receive PHI.

5. Reach cannot and does not guarantee e-mail communication will be private. Reach will take reasonable steps to protect the confidentiality of e-mail received; but, the patient/client and/or legal representative(s) agrees to hold Reachharmless for any e-mail transmission that is intercepted or disclosed in the absence of any gross negligence or wanton misconduct by Reach.

6. The patient/client and/or legal representative(s) may withdraw this consent and any time via e-mail or written communication.

The undersigned has been informed of the risks associated with the use of e-mail, has read and understood this consent, and hereby consents to the use of e-mail to transmit PHI between the patient-client and/or legal representative(s) and Reach for the Top.

Patient/Client Name: _____ DOB_____

_____ _____

Signature of Patient/Client or Legal Representative Date

Please, indicate you relationship to patient/client: SELF PARENT LEGAL GUARDIAN OTHER : _____

Witness: _____ Date _____

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Reach for the Top
Therapy Services

MEDICAID NOTICE AND AGREEMENT

Is your child actively covered by **New Hampshire MEDICAID** (Health Insurance Program)? **YES / NO**

If no, you may skip this form

If **yes**, please indicate whether coverage is: **PRIMARY or SECONDARY** and complete this form.

I, _____ being the parent/legal guardian of

(patient/client) _____ hereby acknowledge the following:

I am aware that my child's healthcare policy via **NH Medicaid only allows 20 visits (*units*) per fiscal year.** The program's fiscal year begins every **July 1st** and ends on the following **June 30th.** I understand **this allotment must be shared by any and all facilities where my child receives physical, speech, and/or occupational therapies.** If my child is seen at any other location for treatments elsewhere and NH Medicaid denies visits based on "OVER ALLOWED UNITS", **I will be held responsible for any unpaid balances beyond the allocated 20 visits (*units*).**

If your child is currently receiving **Physical Therapy, Speech Therapy, and/or Occupational Therapy** please list below the type of therapy he/she receives, the facility's name and location, the provider's name, and the number of times per week your child is treated.

TYPE:_____ NUMBER OF TIMES PER WEEK:_____
FACILITY NAME & LOCATION:_____
PROVIDER/THERAPIST'S NAME:_____

TYPE:_____ NUMBER OF TIMES PER WEEK:_____
FACILITY NAME & LOCATION:_____
PROVIDER/THERAPIST'S NAME:_____

Please, note: If your child is being seen by a therapist(s) only at Reach for the Top and additional visits (units) are necessary to continue treatment, our agency will submit the required documentation to NH Medicaid as an attempt to request these units.

_____

Parent/Legal Guardian Signature **Relationship to client** **Date**

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Reach for the Top
Therapy Services

NOTICE OF INFORMATION PRACTICES

COMPLIANT WITH THE PRIVACY REGULATIONS OF

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Privacy and Security Rules

I have received a copy of the Reach for the Top Therapy Services Notice of Information Practices for Release of Health Information in compliance with the Privacy Regulations of HIPAA and am are of its contents.

Signature: _____ Date:_____

Witness: _____ Date:_____

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Reach for the Top
Therapy Services

Receipt and Acknowledgement of

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received and have been given an opportunity to read a copy of Reach for the Top's NOTICE OF PRIVACY PRACTICES, located in my Client Handbook. I understand if I have any questions regarding the notice of my privacy rights, I may discuss them with a Reach for the Top therapist, office manager, and/or program director.

NOTE: If client is a minor, please list his/her name with date of birth and sign below. Thank you.

Client's Name:_____ **DOB:**_____

_____

Parent/Legal Guardian Signature **Date:**

_____

Please, PRINT signature name.

_____

Witness **Date:**

Title and Location:_____

Reach for the Top: McConnell Center, 61 Locust Street, Dover, NH 03820
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Reach for the Top Therapy Services

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Date: _____

I, _____ , the _____

(Client or parent/guardian) (Relationship-if applicable)

of, _____ , DOB: _____ authorize,

(Print name of dependent-if appropriate)

Reach for the Top Dover, NH **Phone**: 603-740-3534 **Fax:** 603-740-3684

To disclose/receive information to/from:

Name/Organization: _____

Address: _____ **City/State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

The disclosure of information authorized is limited to the following (Please select all that apply):

___Progress Notes
___School Records: Psychological, IEP, etc.
___Service Plan: ISP, RSP, IFSP
___Adoption Reports
___Treatment Plan
___Specialist Consulation Reports
___Physical/Medical Exam Records
___Evaluations
___Lab Results
___Medication History
___Neuro-Imaging Results
___Vocational/Employment
___Financial/Budget information
__Functional/Skills Assessment(s)

Other:

Dates: of Services: _____

This authorization extends to the release of records that may be related to (mark applicable choices):

___ Alcohol Abuse ___ Drug Abuse ___Psychiatric ___Genetic Testing ___ HIV Diagnosis and Treatment

If a specific box is checked, that specific information WILL be released.

It is required for the following purposes: □ Coordination of Care □Evaluation of Services

□ Relocation of Services □ Other: _____

Unless earlier revoked, this authorization terminates on: One year from date of signature or _____

This Authorization permits Reach for the Top to use or disclose your Protected Health Information for purposes other than your treatment, payment to the Provider or the health care operations of the Provider. You have the right to revoke this Authorization by providing the Provider with written notice of revocation. The revocation will be effective upon receipt by the Provider except with respect to uses or disclosures made prior to receipt and in reliance upon this Authorization.

The Provider cannot require you to sign this Authorization as a condition to the provision of services.

Please note that once the requested information is disclosed pursuant to this Authorization, the Provider will no longer have control over the information and there is a potential that it may be re-disclosed by the recipient and will no longer be protected by the privacy rules under the Health Insurance Portability and Accountability Act.

_____ _____ _____ _____

Print Name client or client/guardian) Signature (client or client/guardian) Date Signed

Reach for the Top
Therapy Services

APPOINTMENT PREFERENCE REQUEST

Please, indicate below your top three day and time choices for your child's therapy appointments. If you are flexible, please indicate whether you prefer scheduling during morning hours (AM) or afternoons (PM). Please, understand that we cannot guarantee your preferences; however, we will try our best to accommodate your needs. Thank you.

1._____ _____
(day) (time)

2. _____ _____
(day) (time)

3. _____ _____
(day) (time)

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