APPLICATION FOR SERVICES

Patient Information:

Name: _____ **DOB:**_____**Gender:** M / F

Address: _____

Home Phone: _____**Cell Phone:**_____**Mobile Carrier:** _____

Can we leave a message regarding appointments on your home and mobile phone(s)? Y / N

Primary Care Physician: _____ **Practice Name:** _____

Email Address: _____ **Services Requested:** _____

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

_____

Is your child receiving PT / OT / SP services elsewhere? Y / N **If yes, where?**_____

Are those services being billed to your insurance company? Y / N

Responsible Payer Information:

Name(s): _____ **Relationship to Patient:** _____

Address: _____ **Email:** _____

Phone:_____ **Work Phone:**_____

Billing Information (Please list all):

☐ **NO INSURANCE**

Primary Insurance: _____ **Secondary Insurance:** _____

ID #: _____ **ID #:** _____

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

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

**** Terms of Agreement ****

FINANCIAL RESPONSIBILITY: I hereby assign Reach for the Top Therapy Services 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 for the Top Therapy, 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 efforts to collect any money due to my account.

_____ _____

Parent/Legal Guardian Signature **Date**

_____ _____

Witness **Date**

In the event of an emergency, please contact:

Name	Relationship	Home Phone	Work or Cell Phone

Who lives in your home?

Name	Relationship	Age

Are there pets at home? Y / N **If Yes, What kind:** _____

_____

Complications during mother's pregnancy, labor and delivery? Y / N **If Yes, please describe:** _____

_____

_____

_____

Birth Order: _____ **Birth Weight:**_____ **Premature / Post Mature / Full Term**

Mark any of the following that your child has had a history of:

☐Chronic illness ☐Chronic infections ☐ Fever ☐ Respiratory issues

☐Vision problems ☐Hearing problems ☐ Ear infections ☐Heart issues

☐Sleeping problems ☐Feeding difficulties ☐Diabetes ☐Seizures

☐Meningitis ☐ Tuberculosis ☐Neurological issues ☐Orthopedic issues

☐Other: _____

Describe anything checked: _____

_____

_____

Please list any other illnesses (other than typical childhood illnesses), hospitalizations, surgeries, and physical Injuries your child has had: _____

_____

Are Immunizations up to date? Y / N

Is your child attending early intervention / Head Start / Child Care / School? Y / N **If Yes, Where?** _____

_____

Grade level? _____ **Does your child have a current IFSP / IEP / 504 Plan?**_____

Does your child receive any services through school? Y / N **If Yes, what services?** _____

Please indicate other diagnoses your child has received:

Diagnosis	Approximate Date of Diagnosis

Please list other physicians and specialists who provided care to your child:

Name / Location	Specialty	Phone Number

Current Medications:

Name	Dosage	Frequency	Reason for Medication

Any known allergies? Y / N **If yes, please list:** _____

Is your child on a special diet? Y / N **If yes, please describe:** _____

Vision tested: Y / N **Where:** _____ **Glasses:** Y / N

If yes, date of last vision test: _____ **Results:** _____

Hearing tested: Y / N **Where:** _____ **Hearing Aids:** Y / N

If yes, date of last hearing test: _____ **Results:** _____

Does your child use any medical equipment? N/A **Wheelchair:** Y / N **Standers:** Y / N **Walkers:** Y / N

Specialized Equipment: _____

Does your child have orthotics: Y / N **If Yes, What kind:** _____

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

Sat: _____ **Crawled; Belly:** _____ **Hands & knees:** _____

Walked: _____ **First Word:** _____ **First sentence:** _____

Undressed self: _____ **Dressed self:** _____ **Toilet trained:** _____

Managed snaps: _____ **Managed zippers:** _____ **Managed buttons:** _____

Tied Shoes: _____ **Preferred Hand:** L / R

How did you hear about Reach for the Top? _____

Patients Name: _____ **DOB:**_____

REQUEST AND AUTHORIZATION FOR TREATMENT: I hereby request and authorize the Therapist of Reach for the Top Therapy to administer all diagnostic and treatment procedures and / or services as is required for the above named client. _____ **(Initial)**

RELEASE OR 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. _____ **(Initial)**

***Notice of Privacy Practices (HIPAA Acknowledgement/Consent*:** I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Reach for the Top Therapy. In addition, I hereby consent to the use and disclosure of my child's personal health information for the purpose of treatment, payment, and health care operations. I understand that Reach for the Top Therapy also serves as a training facility and at times other therapists may be observing, handling, or have access to my child's medical information. I authorize Reach for the Top Therapy to obtain medical records and/or professional information from my child's physician or other medical professionals as it relates to my child's treatment.

I have read and understand Reach for the Top Therapy's Notice of Privacy Practices:

_____	_____	_____
Parent/Legal Guardian Signature	**Date**	**Relationship to Patient**

Cancellation Policy

Purpose: A Cancellation policy is necessary to help minimize client's 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 clinic at least 48 hours in advance. Patients 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/Legal Guardian Signature	**Date**	**Relationship to Patient**

Please initial the following statements that you are in agreement with:

_____ I agree to allow Reach for the Top Therapy staff to send email reminders to the email address I have provided. **Email Address:** _____

_____ I agree to allow Reach for the Top Therapy staff to text appointment reminders to the cell phone I have provided. **Cell Phone #:** _____ **Mobile Carrier:** _____

_____ I understand Reach for the Top Therapy Clinic supports students in a wide variety of fields. I agree to allow students to observe / shadow sessions with my child's treating therapist.

_____ I will not use my cell phone when I am in the therapy gym, unless specified by the therapist for home

_____ I hereby authorize Reach for the Top Therapy to take photographs, videotapes, movies or video recordings of my child. Photographic, audio or video recordings may be used for the following purpose: conference presentations, education, staff development, and grant applications.

Would you like to receive your bills via email? **YES / NO**

Appointment Preference Request

Please, indicate below your three day and times choices for your child's therapy appointments. If you are flexible, please indicate whether you prefer scheduling during mornings 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)**

Patients Name: _____ **DOB:**_____

Medicaid Notice and Agreement

Is your child actively covered by New Hampshire MEDICAID? Y / N

If NO, you can skip this form.

If YES, please indicate whether coverage is: ☐Primary ☐Secondary **and complete this form.**

I**,**_____ being the parent / legal guardian of _____ 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 therapy. If my child is seen at any other location for treatment 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, speech or occupational therapy please list below the type of therapy he/she receives, the facility's name and location, the providers 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.