New Hope Therapy Centers

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GREENSBORO
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Greensboro, AL 36744
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Therapy Intake Form

To help better serve you, please provide us with the information requested below. Please be assured that the information you provide will be held confidential and is necessary for our staff to determine and provide appropriate evaluation and therapy services.

Today's Date: _____

Child's name: _____ Sex: M ☐ F ☐

Date of birth: _____ Age: _____ Grade Level: _____

Diagnosis: _____ Age of Diagnosis: _____

Referring Physician: _____ Office number: _____

Main concerns:

Please list 3 goals you would like to see your child achieve in therapy:

1. _____
2. _____
3. _____

Please list strong motivators for your child. (Activities, toys, movies, foods, songs, etc.)

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1st Guardian name: _____ Relationship to child_____

Address: _____ City: _____

Zip code: _____ Email: _____

Cell Phone: _____ Employer: _____

2nd Guardian name: _____ Relationship to child_____

Address: _____ City: _____

Zip code: _____ Email: _____

Cell Phone: _____ Employer: _____

Specify who has legal custody: _____

What languages are spoken in home: _____

List **ALL** emergency contacts or any family that will be bringing child to appointments:

Emergency contact: _____ phone: _____

Relationship: _____

Secondary contact: _____ phone: _____

Relationship: _____

Extra contact: _____ phone: _____

Relationship: _____

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Medical History:

Add any prior hospitalization or major ER visits:

Any major allergies that the therapist should know about:

Any previous or current therapy services? (Where, when, and duration)

_____

_____

_____

Please list the child's current school / daycare that they attend:

School Name: _____ Grade: _____

Any services received at school: _____

Acknowledgment of Notice of privacy practices

I have read and understand the Notice of Privacy practices provided to me with this packet.

Authorization Signature: _____ Date: _____

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Communication with Parents / Guardians through text:

The clinics main form of communication is via text messaging from the clinic phone. We use this form of technology to inform parents of upcoming appointments, scheduling changes, weather announcements, and other clinic or therapist updates. Please make sure all phone numbers provided in patient history and contact methods can receive text. Signing below ensures that you understand the main form of communication within our clinic.

Signature: _____ Date: _____

Bathroom Policy:

When arriving for your child's therapy appointments please know that our company policy does not allow the employees of the clinic to change or assist in your child using the bathroom. That being said, please make sure if your child is not fully potty trained that they arrive to therapy with a clean pull-up/diaper on to ensure that we provide the most time efficient and best quality therapy that we are capable of offering. Please also stay in the vicinity of our clinic in case your child urgently needs to use the bathroom. By signing you agree to these terms and understand our Bathroom policy.

Signature: _____ Date: _____

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Authorization and consent for treatment

I consent to and grant permission to the employees of Helping Hands Therapy dba New Hope Therapy center to render to my child routine clinical care including evaluations, educational services, and therapy activities/procedures during my recipient of services. I also acknowledge that Helping Hands Therapy dba New Hope Therapy has not made any guarantee or warranty as to the result of any services or treatments given.

Authorization Signature: _____ Date: _____

Consent to bill health insurance

Helping Hands Therapy dba New Hope Therapy is considered in-network for most major insurance carriers. If you have out-of-network benefits with your insurance plan, it may be possible to be reimbursed by your insurance company for therapy services.

Helping Hands Therapy dba New Hope Therapy will verify benefits only upon the initial evaluation/treatment session. Verification of benefits is not a guarantee of coverage or payment, and all insurance payments are subject to medical necessity and eligibility at the time services are rendered. I understand that an office visit and specific therapy charges are incurred at each appointment. Knowledge of maximum number of visits, deductible amounts and out of pocket maximums are the responsibility of the patient. Co-pays, deductibles, and coinsurance are due at the time of service. It is your responsibility to update on us on any changes made to your insurance. Questions regarding insurance claims or payments should only be directed to the billing department of Helping Hands Therapy dba New Hope Therapy center and not to treating therapist. I consent for Helping Hands Therapy dba New Hope Therapy center, including its providers to bill my private health insurance. I also consent to the release of any information necessary to file a claim with my health insurance plan.

Authorization Signature: _____ Date: _____

Primary Insurance:

Insurance name: _____ Member ID: _____

Group policy # _____ Effective date: _____

Policy holder name: _____ DOB: _____

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Consent for Client pictures

As a whole, Helping Hands Therapy dba New Hope Therapy center would like to periodically feature clients and celebrate their successes by sharing their experiences in the clinic. The law requires that we ask for your permission to use these types of images of your child, but more importantly, we only wish to celebrate your child in an environment that is comfortable for both you and them. With your permission, we will share your child's successes on our social media, and you will be able to download, save and or share those images as you choose. We will never use your child's name or any other personally identifiable information in any of our postings. If you, as a parent/guardian, wish to rescind this agreement, you may do so at any time in writing, which will take immediate effect upon receipt by Helping Hands Therapy dba New Hope Therapy center.

☐ I grant permission for the photo/image that includes my child, without any other personal identifiers, to be published on the Helping Hands Therapy dba New Hope Therapy center website/Facebook/Instagram

☐ I DO NOT grant permission for the photo/image that includes my child, without any other personal identifiers, to be published on the Helping Hands Therapy dba New Hope Therapy center website/Facebook/Instagram

Child's name: _____

Guardian/parent: _____

Relationship to child: _____

Printed Name: _____

Authorization Signature: _____ date: _____

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New Hope Therapy Appointment and No-Show policy

For all patients with private insurance:

If you are unable to keep your scheduled appointment time, please call our office **at least 24 hours in advance to avoid a $25 missed appointment fee**. This charge is not covered by insurance. Your phone call is critical in helping us provide continuous care to all our valued patients. **For the missed appointments following, you will be charged the $25 missed appointment fee.** After 3 consistent canceled or no shows on your child's attendance your child will be taken off the New Hope schedule.

For all patients with Alabama Medicaid insurance:

If you fail to give us notice of your missed appointment, we cannot schedule our therapist appropriately. If your child cancels consistently or no shows 3 or more times, we will assume you no longer desire to receive therapy and will remove your child from the New Hope Therapy schedule. We will be more than happy to forward any medical records to your next desired facility.

By signing this document, I understand and agree with the "Appointment and No-show policy: listed above.

_____ _____

Patient / Legal Guardian Signature Date

_____ _____

Patients name Date

DATE OF MISSED APPT	FEE? Y/N	NOTES	PT INITALS