Phone: 601-270-6968 Fax: 601-336-5255
Email: office@aultmanspeechtherapy.com
Website: www.aultmanspeechtherapy.com

New Patient Intake Packet for Occupational Therapy

(Please print clearly)

Patient Name:	Date of Birth:	Gender: ☐ Male ☐ Female
Guardian Name and Relationship to Patient:	Phone #: home: cell:	
Physical Address:	City/State/Zip:	
Mailing Address: (If different from above)	City/State/Zip:	
Email address for Patient Portal:		

Emergency Contact (must be different than parent/guardian listed above):

Name:_____ Relationship to Patient:_____

Phone #: _____ May we disclose your child's treatment and health information to this person? ☐ Yes ☐ No

Primary Care Doctor (doctor you will sign off on your therapy):	Doctor's Phone #:

Primary Insurance Company:	Insurance Policy #:
Policyholder's Name: Relationship to Patient:	Policyholder's Date of Birth: Policyholder's SSN:
Policyholder's Employer:	

Secondary Insurance Company (if applicable):	Secondary Insurance Policy #:
Secondary Insurance Policyholder's Name: Relationship to Patient:	Secondary Policyholder's Date of Birth: Secondary Policyholder's SSN:
Secondary Insurance Policyholder's Employer:	

**We will need a copy of the front and back of the insurance card(s). You can send copies with this paperwork packet, email to office@aultmanspeechtherapy.com, text a screenshot to 601-270-6968, or fax to 601-336-5255.*

Patient Name: _____

Requested Location for Services: ☐ Hattiesburg Office ☐ Sumrall Office

☐ Daycare/School that we currently service _____

Requested time for services: ☐ morning ☐ afternoon
**this is not a guarantee of availability-we will contact to offer what times are available*

Does your child currently receive occupational therapy? □ No □ Yes
If yes, provider/clinic name: _____

Has your child received occupational therapy in the past? □ No □ Yes
If yes, provider/clinic name: _____
Dates of previous occupational therapy: _____

Is your child currently enrolled in school? ☐ Yes ☐ No
Name of School: _____ Current Grade: _____
If homeschooled-what program is used? _____
Has your child repeated a grade? ☐ Yes ☐ No If yes, which grade? _____

Does your child receive any special services from school, a physician, or agency (special education teachers, audiologists, psychologists, ABA therapy, etc)? ☐ Yes ☐ No

If yes, list the provider and type of services.

Family Information-Please list everyone who lives in the same home as the child:		
Name	**Age**	**Relationship to child**

Please describe any concerns you feel Occupational Therapy will help (please include when the issue was first noticed, and any other information that the therapist may need to know).

Has your child's doctor noticed or been notified of these concerns? If yes, what were his/her recommendations?

Patient Name: _____

Developmental History and Current Information
Has your child been diagnosed with a Developmental Delay (late walking, talking, etc)?
Does your child have any physical handicaps?

Approximate age that your child was able to do the following activities:

Sit up _____ Crawl _____ Walk _____ Say First Word _____

Scribble_____ Copy Lines_____ Write words _____ Write sentences _____

Snip with Scissors_____ Rode a tricycle _____ Rode a bicycle _____

Fed Self: Spoon _____ Fork _____

Does your child communicate verbally? YES_____ NO_____

If your child is non-verbal, describe how they communicate with you.

Dressing Skills	
□Yes □No	Can child independently dress self?
□Yes □No	Can child button and zip clothing?
□Yes □No	Does child need occasional assistance to dress?
□Yes □No	Does parent dress child on a daily basis?
□Yes □No	Does child push arms through sleeves and legs through pant legs?
□Yes □No	Does child independently brush teeth?
Please add any comments or concerns regarding Dressing Skills here:	

Motor Skills	
□Yes □No	Does your child appear clumsy or uncoordinated?
□Yes □No	Does your child have difficulties with handwriting?
□Yes □No	Does your child occasionally need a reminder to use utensils?
□Yes □No	Does your child never use utensils?
□Yes □No	Does your child eat an adequate amount of food for his/her age?
□Yes □No	Is your child willing to sit at table/highchair for all meals?
Please add any comments or concerns regarding Motor Skills here:	

Patient Name: _____

Feeding Skills	
□Yes □No	Is your child a picky eater?
□Yes □No	Does your child avoid certain foods due to texture?
□Yes □No	Does your child use a spoon/fork at every meal?
□Yes □No	Does your child occasionally need a reminder to use utensils?
□Yes □No	Does your child never use utensils?
□Yes □No	Does your child eat an adequate amount of food for his/her age?
□Yes □No	Is your child willing to sit at table/highchair for all meals?
Please add any comments or concerns regarding Feeding Skills here:	

Social Interactions	
□Yes □No	Does your child play with age appropriate toys?
□Yes □No	Does your child respond when his/her name is called?
□Yes □No	Does your child have difficulties with transition to new activities/environments?
□Yes □No	Does your child have difficulties with changes in routine?
□Yes □No	Does your child get frustrated easily?
□Yes □No	Does your child have difficulties calming and coping with anger?
□Yes □No	Do you have concerns about your child's ability to play with other children?
Please add any comments or concerns regarding Social Interactions here:	

Sensory Processing-Check all that apply	
☐ difficulty/dislikes washing/cutting hair	☐ avoids swings/climbing/movement
☐ difficulty/dislikes cutting fingernails	☐ engages in risky play activities
☐ difficulty/dislikes brushing teeth/oral care	☐ prefers rough play
☐ difficulty calming down	☐ craves movement
☐ difficulty focusing attention	☐ constantly moving/"on the go"
☐ sensitive to loud and unexpected sounds	☐ overly shy
☐ sensitive to clothing fabrics/textures	☐ sleeping problems
☐ avoids messy play/getting dirty	
Please add any comments or concerns regarding Sensory Processing here:	

Patient Name: _____

***Initial each line**

Authorization of Services

_____I hereby authorize Aultman Speech Therapy Services, LLC's Occupational Therapists, Certified Occupational Therapy Assistants (COTA), and/or Occupational Therapy students to screen, evaluate, and treat the above-named patient as the need is indicated by his/her attending physician. I authorize Aultman Speech Therapy to request and/or release Protected Health Information including medical records, treatment records, diagnostic records, and IEPs as necessary to individualize therapy needs and/or obtain insurance prior authorization. This includes but is not limited to physicians, teachers, other school representatives and other therapists. I also authorize Aultman Speech Therapy to take photographs of above-named patient if needed to be used as part of his/her Protected Health Information that may be released as indicated above.

Communication Authorization

_____I hereby authorize Aultman Speech Therapy Services, LLC to send a Patient Portal email as well as any other email communication to the email address listed on page one of the New Patient Intake Packet for Occupational Therapy. I understand that I will receive an email from Ensora Rehab Therapy Suite to set up a password for the Patient Portal. Once the password is set up, I understand that I will need to save the link to access the Patient Portal.

_____I understand that the Patient Portal gives access to pay on my account balance, as well as having access to my child's Occupational Therapy Records (Protected Health Information). Which can be used for personal use or to share with others needing his/her therapy records.

_____I hereby authorize Aultman Speech Therapy, any employees and Ensora Rehab Therapy (or other associated EMR) to send text messages to the number(s) listed on page one of the New Patient Intake Packet or any updated/added number.

_____I understand that it is my responsibility to contact Aultman Speech Therapy via phone call, text, fax or email (not secure for PHI) to update **ALL** changes to phone numbers, addresses, insurance, etc.

Attendance Policy

_____I understand that if I am unable to keep my child's therapy appointment, I will notify my child's therapist by phone call or text as soon as possible. I understand that attendance is an important aspect of my child's progress and insurance may not continue to give authorizations for service if my child is missing sessions. **We know things happen and there are going to be some absences due to illness, planned vacations, and a few unexpected things. Please understand that we are a small business: our business and therapists are only compensated when your child attends their scheduled therapy sessions.*

_____I understand that arriving late may result in a shortened visit or the need to reschedule.

_____I understand that my child can be discharged from therapy if any of the following are met:

*Two (2) consecutive "No-Show" appointments (missed appointments with no previous notification)
*Four (4) cancellations within a 2-month period
*No progress and/or HEP (Home Exercise Plan) not being followed: Therapy is a partnership and all parties must work together for the child's success.
*Delinquent payments on account

_____I understand that if I choose to terminate services, the request needs to be in writing. The termination of services request can be emailed to office@aultmanspeechtherapy.com or faxed to 601-270-6968.

Patient Name: _____

***Initial each line**

Insurance Authorization

_____I hereby authorize the release of any medical or other information necessary to process insurance claims and request payment of benefits to Aultman Speech Therapy Services, LLC for services rendered to the patient. I understand that I am financially responsible for any charges not covered by insurance.

_____I understand that insurance requires my child's physician to sign off on his/her plan of care. I understand that it is my responsibility to ensure my child has current appointments with the physician listed on page one of the New Patient Intake Packet for Occupational Therapy to discuss therapy so that insurance will continue to cover services. **If my child has MS Medicaid, I understand that they do require a visit with the physician **every 6 months**.

Financial/Payment Policy

_____I understand that I am financially responsible for payment of all charges for services rendered including what is not covered by insurance (co-pays, deductibles, co-insurance, etc.).

_____I understand that it is my responsibility to watch my EOBs (Explanation of Benefits) from my insurance for the amount "owed to provider". If I have any questions or concerns about the amount shown, I will contact the Office Administrator at 601-270-6968 to discuss.

_____I understand that invoices will be emailed monthly from Ensora Rehab Therapy to the email address listed on page one of the New Patient Intake Packet for Occupational Therapy. If I prefer to receive both an email and a paper copy of the invoice, I understand that it is my responsibility to contact the Office Administrator to make this request. **The high cost of postage has led to this change for our small business.*

_____I understand that I can call the Office Administrator at 601-270-6968 to get my current balance owed.

_____I understand that payment is required **in full** each month. Payments can be made by "Click to Pay" on your emailed invoice, your patient portal, credit card over the phone at 601-270-6968, or by check mailed to 4805 W 4th St Hattiesburg, MS 39402 ($20 fee for all returned checks).

_____I understand that failure to pay my account may result in my account being turned over to small claims court. In such cases, I will be responsible for all additional costs incurred, including court fees, legal expenses, and other related charges.

I have been provided with a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to read and understand as well as a copy of the Authorizations and Policies that I have initialed above. I, the undersigned acknowledge and accept the authorizations and policies set forth by Aultman Speech Therapy Services, LLC. I understand that my initials and signature indicate my agreement to the terms and conditions outlined in these forms.

_____ _____

Signature Date

*By signing, I confirm that I am the authorized parent/legal guardian for the child listed within these forms.

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Parent/Guardian Copy

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Privacy Policy

Objective

Aultman Speech Therapy Services, LLC has adopted a policy that protects the privacy and confidentiality of protected health information (PHI) whenever it is used by company representatives. The private and confidential use of such information will be the responsibility of all individuals with job duties requiring access to PHI in the course of their jobs. You may request a detailed copy of our HIPAA Notice of Privacy Practices Policy.

Protected Health Information (PHI) Defined

PHI refers to individually identifiable health information, including but not limited to demographics, medical conditions, health status, claims experience, medical histories, physical examinations, genetic information and evidence of disability.

The HIPAA Privacy Compliance Officer

Aultman Speech Therapy Services, LLC has a designated HIPAA compliance officer (HCO), and any questions or issues regarding PHI should be presented to the HCO for resolution. The HCO is also charged with the responsibility for:

- Issuing procedural guidelines for access for PHI.
- Developing a matrix for personnel who will need access to PHI.
- Developing guidelines for describing how and when PHI will be maintained, used, transferred or transmitted.

Annual Activities Necessitating Use of PHI and Your Rights under the HIPAA Privacy Rule

Annually or more frequently as necessary, Aultman Speech Therapy Services, LLC provides assistance in insurance claims problem, resolution, and explanation of benefits issues; assists in coordination of benefits with other providers; update medical records as needed. Some or all of these activities may require the use or transmission of PHI. Thus, all information related to these processes will be maintained in confidence, and employees will not disclose PHI from these processes for employment-related actions, except as provided by administrative procedures approved by the HCO. General rules follow:

- Disclosures that do not qualify as PHI-protected disclosures include:
  - Disclosure of PHI to the individual to whom the PHI belongs.
  - Requests by providers for treatment or payment.
  - Disclosures requested to be made to authorized parties by the individual PHI holder.
  - Disclosures to government agencies for reporting or enforcement purposes.
- Information regarding whether an individual is covered by a plan for claims processing purposes may be disclosed.
- Information is being furnished for claims processing involving workers' compensation, ADA or FMLA status.

You have a right to request in writing a copy of your PHI unless otherwise prohibited by federal law.

Records Retention

Personnel records and disclosures of PHI will be maintained for a period of six years as required by federal law, unless a state law requires a longer retention period. Records that have been maintained for the maximum interval will be destroyed in a manner to ensure that such data are not compromised in the future in accordance with the company record destruction policy.

Parent/Guardian Copy