PATIENT NAME _____

Achievement Therapy Center, LLC

Therapy for Children

235 E. 9th Ave. Anchorage, AK 99501

(907) 334-9001 or (907) 301-9201

atherapycenter@gmail.com • FAX (907) 868-8657

www.TherapyForChildren.net

Patient Intake / Billing Information

Today's Date _____ / _____ / _____

Last Name _____ First Name _____ M _____

Date of Birth _____ / _____ / _____ Age _____ Sex ____ M or ____F

Parent or Guardian Name _____

Address of Child _____ Phone (_____) _____ - _____

City _____ State _____ ZIP _____

Mailing Address _____ Phone (_____) _____ - _____

City _____ State: _____ Zip: _____

Email _____ Do You Text? ____ Y or____ N

Primary Care Physician _____

Emergency Contact _____ **Phone (_____) _____ - _____**

Primary Insurance

Ins. Company Name _____ Policy # _____ Group # _____

Insurance Holders Name _____ Insured's Employer _____

Insured's DOB ____ / ____ / _____ Relationship to Insured _____ SS# _____ - _____ - _____

Insurance Address _____ Phone (_____) _____ - _____

Secondary Insurance

Ins. Company Name _____ Policy # _____ Group # _____

Insurance Holders Name _____ Insured's Employer _____

Insured's DOB ____ / ____ / _____ Relationship to Insured _____ SS# _____ - _____ - _____

Insurance Address _____ Phone (_____) _____ - _____

******* Please Provide a copy of your Insurance Card(s) or Medicaid Sticker *******

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FINANCIAL POLICY STATEMENT

Thank you for choosing **Achievement Therapy Center, LLC** for services. We are committed to providing you with the best possible care. Your understanding of our financial policy is important to our professional relationship. The following is our Financial Policy, which we require you to read and sign prior to any treatment. Please ask if you have any questions about our fees, financial policy, or your responsibility.

WE ACCEPT CASH, CHECKS, AND CREDIT CARDS.

INSURANCE

Insurance is a contract between you and your insurance company. You are responsible for the timely payment of your account. Co-payment, if applicable, deductibles and co-insurance is payable at each visit. *Achievement Therapy Center, LLC* maintains an office policy to bill your insurance company as a courtesy to you. Once the carrier is billed, we will set aside the portion of the balance estimated to be paid by your insurance carrier for 60 days. We require that your estimated share be paid at the time the services are rendered. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you at that time. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments or covered charges other than to supply factual information as necessary.

Achievement Therapy Center, LLC will obtain verification of insurance and follow up with authorization for our services whether from your Primary Care Physician or directly from your insurance policy authorization department. Please be advised, an authorization for services does not guarantee payment of services rendered until an actual claim is received. If your insurance company will not cover the incurred charges, payment is due upon receipt of services. Payment of all outstanding accounts is due in full before discontinuing therapy with *Achievement Therapy Center, LLC* regardless of outstanding insurance payments. No information will be released from this office until the entire balance is paid in full.

I understand that in the event payment is not made in a timely manner, information of my delinquent account will be forwarded to the collection agency, which also reports to the credit bureau and a reasonable processing fee will be added to the balance of my account.

MISSED APPOINTMENTS

In order to ensure that all patients are scheduled for treatment in a timely manner, *Achievement Therapy Center LLC* has found it necessary to implement a policy of charging $40 for appointments not kept, or broken without at least an 8-hour prior notice (unless due to illness).

OTHER INFORMATION

Our clinic strives to provide the best therapy services possible. In order to ensure optimal use of valuable therapy time, please discuss schedule changes with your therapist. We understand occasional changes are necessary due to illness, vacations etc. When you know you cannot make your scheduled appointment, please call our clinic as soon as possible. If you do not call, this missed appointment is counted as a no-show. **Two consecutive no-shows** require your child to be placed on hold status until the issue of missed appointments is resolved. If a resolution is not made within 5 business days, your child will lose his/her therapy time and be placed on a waiting list. Consecutive cancellations, without prior knowledge of the therapists, may also lead to a hold status. We are happy to work out scheduling problems with you, as able. Please let us know if you are experiencing a problem with your current schedule. Be assured that we will do our utmost to be considerate of you when it becomes necessary for our therapists to cancel or reschedule your appointments.

APPOINTMENT TIMES

Please arrive on time for your appointment. If you are late, this will reduce your child's therapy time and this portion of missed time cannot be made up. If you know you will be late, please call your therapist as soon as possible.

Please feel free to discuss any questions you may have regarding these policies. Your signature below indicates you agree with and will abide by these terms. We appreciate your cooperation in these matters.

We appreciate at least 24-hour notice for any cancellation. We understand children can become ill suddenly or unforeseen circumstances may arise leading to occasional short notice cancellations. However, frequent cancellations by any one patient will be reviewed and you will be notified if we find it necessary to charge for any further cancellations. If you do not notify us that your child is going to be absent from a scheduled therapy session, you will be charged.

If you are late for your appointment, you will be expected to pay for the full appointment and we can see you for the remaining amount of the session.

We reserve the right to not see a child who arrives more than 15 minutes late. If more than three appointments are missed without proper cancellation, we reserve the right to discontinue services.

MY SIGNATURE BELOW INDICATES THAT I AGREE TO ALL OF THE ABOVE STATEMENTS.

X _____ Date _____ / _____ / _____

Parent Signature

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Release, Assignment and Statement of Responsibility

I authorize *Achievement Therapy Center, LLC* or/and its agents to bill my insurance carrier directly and agree to be responsible for all amounts not covered by the insurance company. I also agree to allow *Achievement Therapy Center, LLC* to release any medical records that are requested by the insurance carrier for payment of service.

I hereby authorize payment directly to *Achievement Therapy Center, LLC* for therapy rendered.

X _____ Date _____ / _____ / _____
Parent or Legal Guardian Signature

Consent to Treatment

I, _____, give permission for:

_____ (minor child) to be evaluated by the following professionals:

_____ *Achievement Therapy Center, LLC* (including all occupational therapists and/or speech therapists on Staff.
Initial

_____ I give permission to photograph/videotape my child for the
Initial purposes of evaluation, treatment, plans of care, education and documentation.

By signing below, I give my consent for examination and the performance of any tests or procedures necessary to evaluate and treat the above minor patient.

X _____ Date _____ / _____ / _____
Parent or Legal Guardian Signature

_____
Printed Name of Parent or Legal Guardian

Release of Liability

I as the undersigned acting as legal guardian and or legal power of attorney, give my informed consent for child

_____, to participate in any Occupational or Speech Therapy activity that is conducted in any location, this includes, on-site and community based therapeutic activities. These activities may include but are not limited to sports, water, boats, bicycles, swings, playgrounds, climbing walls, snow, ice, all wheeled recreational items, balls ropes and jumping from various heights, trees, and interaction with other children or persons. I am aware that there are inherent risks in participating in activities that may challenge my child and I accept and am aware of these. In the event of any physical or mental injuries sustained in any activities facilitated by *Achievement Therapy Center, LLC* and all employees, managers and members of *Achievement Therapy Center, LLC* are released from any and all liability.

This release of liability is perpetual during the treatment time of the above participation person – beginning date of signature below.

Child Name _____ Date _____ / _____ / _____

X _____ Date _____ / _____ / _____
Signature of Parent or Legal Guardian

_____
Printed Name of Parent or Legal Guardian

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Patient Information

Child's Name _____ Date of Birth _____ / _____ / _____

Age _____ Sex ____ M or ____F Preferred Phone (_____) _____ - _____

Parent(s) email address _____

RELEASE OF INFORMATION

List the names of the programs/people that have worked with or are currently working with your child. Please initial in the last column to authorize communication between *Achievement Therapy Center, LLC*, and each of the following.

Service	**Program Name/Location**	**Professional's Name**	**Dates**	**Authorize Release of Information PLEASE INITIAL**
Pediatrician/Physician				
Child Care Program				
Infant Learning Program				
Head-Start Program				
Preschool Program				
Elementary School				
Middle/High School				
Counselors (behavioral or other)				
Public Health Nurse				
Occupational Therapist				
Physical Therapist				
Speech Therapist				
Caseworker				
Other:				
Other				
Other				
Foster Family				

MEDICAL RELEASE OF INFORMATION

I give my permission for the exchange of written/electronic/oral communication between my care providers / doctors / insurance companies, and *Achievement Therapy Center, LLC*. I understand that my child's records may be reviewed by state representatives for the purpose of insurance certification, or by therapists or doctors for the purpose of professional peer review, licensing or quality assurance. I understand that all practices of confidentiality, following HIPPA compliance standards, will be followed in use of the information gathered. I may revoke or limit this permission at any time.

X Parent Signature _____ **Date** _____ / _____ / _____