All For KIDS
Pediatric Therapy Clinic

6927 Old Seward Hwy, Ste. 100
Anchorage, AK 99518
Phone: 907-345-0050

NEW PATIENT INTAKE FORM

PERSONAL INFORMATION

Child's Legal Name: _____ Date of Birth: _____

Age: _____ Male: _____ Female: _____ Primary Care/Pediatrician: _____

Legal Guardian: _____ **Legal Guardian**: _____

DOB: _____ DOB: _____

Please check if it is okay to leave a message	**Yes**	**No**		**Yes**	**No**
Home Ph: _____	☐	☐	Home Ph: _____	☐	☐
Cell Ph: _____	☐	☐	Cell Ph: _____	☐	☐
Work Ph: _____	☐	☐	Work Ph: _____	☐	☐

Best number to reach you at: _____

Email: _____ Email: _____

Physical Address: _____ Physical Address: _____

City, State, Zip: _____ City, State, Zip: _____

Mailing Address: _____ Mailing Address: _____

City, State, Zip: _____ City, State, Zip: _____

Occupation: _____ Occupation: _____

Employer: _____ Employer: _____

Who referred you to our office? _____

Who does the child reside with? _____

Who has custody of the child? _____

If primary person bringing child to therapy is not listed above, please list name and contact phone number of that person: _____

INSURANCE INFORMATION (please fill out ALL areas)

Primary Insurance: _____ Secondary Insurance: _____

Policy Number: _____ Policy Number: _____

Group Number: _____ Group Number: _____

Insured's Name: _____ Insured's Name: _____

Insured's DOB: _____ Insured's DOB: _____

Please **initial** the following statement:

_____ **I <u>DO NOT</u> YOU HAVE ANY OTHER INSURANCE COVERAGE FROM ANY OTHER SOURCE OTHER THAT THE ABOVE MENTIONED.**

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AUTHORIZATION AND CONSENT FOR EVALUATION, TREATMENT, AND OPERATIONS:
Please **initial** the following statements:

_____ I hereby give All For Kids Pediatric Therapy, LLC permission to evaluate and treat my child, and I understand there will be written, oral, and electronic communication between care providers/physicians, insurance companies, and All For Kids Pediatric Therapy, LLC staff.

_____ I understand that state representatives for the purpose of insurance certification or licensing and quality assurance may review my child's records. I understand that all practices of confidentiality will be followed in use of the information gathered.

_____ _____
Parent/Legal Guardian Signature **Date**

EMERGENCY MEDICAL RELEASE
In the event medical attention is required for your child while on the premises of All For Kids, LLC, we need your authorization to implement treatment. Please read and sign the statement below.

As legal guardian of _____, I give my permission for All For Kids, LLC to contact emergency personnel in the event of a medical emergency.

_____ _____
Parent/Legal Guardian Signature **Date**

EMERGENCY CONTACT

NAME: _____ **PHONE:** _____

RELATIONSHIP: _____

MEDICATION/ALLERGIES/CONDITIONS
Medications (Include prescription drugs, over the counter meds, vitamins, and homeopathic medications):

_____

Allergies/Reactions:

_____

Diagnoses (Any known medical diagnosis or medical condition, with dates of diagnosis if known):

_____

PHOTO PERMISSION
Please **initial** the following **OPTIONAL** statements:

_____ I give permission for photos/videos of my child to be used for the purposes of treatment, education, and documentation.

_____ I give permission for photos/video of my child to be used for advertising, brochure, and/or webspace.

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TECHNOLOGY PERMISSIONS
Please **initial** the following statement(s):

_____ **EMAIL ENCRYPTION ACKNOWLEDGMENT (REQUIRED)**: I understand that AFK may correspond with my child's legal guardians and care team via email regarding treatment, home programming, and documentation when requested. I understand that AFK email is encrypted internally; however, once an email is sent externally, email correspondence may be intercepted by an outside party.

_____ **TEXT PERMISSION (OPTIONAL)**: I authorize All For Kids to send text messages to my cell phone related to my child's therapy. I understand that communication via text message is not secure and may potentially be intercepted by a third party. I understand that standard data and text messaging rates will apply to any messages received from AFK. I agree not to hold AFK liable for any electronic messaging charges or fees generated by this service. I understand that AFK text messages to my cell phone are not secure and potentially could be intercepted by an outside party.

TELETHERAPY CONSENT
If yes, please **initial** the following to give your consent.

_____ I give consent for my child to receive speech, occupational, and/or physical therapy via synchronous teletherapy when indicated.

_____ I agree to have a telemedicine facilitator (e.g., parent, guardian, or caregiver) present for teletherapy sessions. The telemedicine facilitator agrees to become competent with the telemedicine technology with training from my child's therapist and will assist my child in understanding and using this technology at the direction of my therapist. The facilitator will be on the premises and physically present if appropriate.

Email for Teletherapy: _____

By Alaska telehealth law we are required to ask if you would like for AFK to send a copy of **all** teletherapy notes to your child's primary care physician. During regular therapy, we do not typically send your child's notes every session unless requested. Would you like to opt out of sending each note or would you like us to fax each note after every session?
_____ Yes, I would like to opt out.
_____ No, please send every note.

_____ _____
Parent/Legal Guardian Signature **Date**

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA):
I acknowledged that I have viewed, read, and understand the HIPAA Policy (attached at the end of this packet) and have been informed of my rights as a patient's parent/guardian.

_____ _____
Parent/Legal Guardian Signature **Date**

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List the names of other providers on your child's care team (e.g., specialist doctor(s), neuropsychologist, counselor, dietician, etc.)

_____

_____

_____

_____

_____

****If your child has an Individualized Education Plan (IEP), neuropsychological evaluation, or any additional relevant reports, please bring a copy for your therapist to review.****

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HISTORY FORM

Please answer the questions to the best of your ability and in as much detail as possible. Please add any information that you feel is important but is not covered on this form.

General History

Child's Name: _____ Nickname? _____ DOB: _____

Current concerns: _____

What are your primary goals for therapy?

_____

Has your child previously received occupational, physical, or speech therapy? To address what concerns? Please include where, when, and for how long:

_____

Is your child currently receiving any of these therapy services? Please list providers, locations, and days/times:

_____

Pregnancy & Delivery

Did the child's mother have any illnesses or complications during pregnancy or delivery? Please describe:

_____

Was your child premature? YES NO

Born at how many weeks gestation: _____ Birth Weight: _____

Did your child require any medical procedures before, during, or after birth? Please describe:

_____

Developmental History

Please indicate at what **age** each major milestone was reached:

Sitting up by self: _____ Crawling: _____ Walking: _____

First word: _____ Two words together: _____

What was their first word? _____ What was their first phrase? _____

When did you first become concerned about your child's development?

_____

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Feeding

Did your child have any feeding problems as an infant? Please describe:

_____

Was your child bottle fed or breast fed and for how long? _____

Did your child have any colic or reflux issues? _____

Describe your child's current eating habits and typical intake:

_____

Medical History

Please describe illnesses, hospitalizations, or surgeries that your child has had and when they occurred:

_____

Is there a family history of speech-language or other developmental delays?

_____

Has your child had a neuropsychological evaluation? YES NO

If yes, date of most recent evaluation: _____ Name of neuropsychologist: _____

Social History & Living Situation

Please describe your child's living situation (and any recent changes):

_____

Siblings' names and ages: _____

If your child was adopted, please answer the following questions:

Age of adoption: _____ Is your child aware of adoption? YES NO

Previous home experiences prior to adoption: _____

Educational History

Grade: _____ Name of school: _____ Teacher: _____

What kind of classroom (e.g., regular ed, special ed, life skills, pull-outs, etc.): _____
Does your child have an IEP? YES NO

What services does your child receive at school through the IEP? _____

Names of any school therapists? _____

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Hearing & Vision

Has your child had his/her hearing tested? When? What were the results? _____

Has your child had any ear infections? Please list number if known: _____

Did your child ever have tubes placed in his/her ears? When? _____

Has your child had his/her vision tested? What were the results? _____

Does your child wear glasses or hearing aids? For what condition? _____

What is the primary language spoken in the home? _____

Personal Information

Please describe your child's personality:

How do you handle discipline issues at home?

Does your child have tantrums? YES NO How often? _____

How does your child handle changes and variation in routine?

How much screen time does your child get (i.e., tablets, smart phones, computer, TV, etc.)?

What games, activities, toys does your child enjoy?

Describe how your child interacts with other children:

Describe your child's sleeping habits/patterns:

Briefly describe a typical day for your family, especially this child (feel free to use the back of this paper, if needed):

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PATIENT AGREEMENT

All For Kids Pediatric Therapy, LLC offers Physical Therapy, Occupational Therapy, and Speech-Language Pathology services for patients referred to our practice. We are a licensed provider who develops individualized treatment plans to identify the services that will best suit your child's therapy needs. We will also work with your primary care practitioner to coordinate your care.

Following the initial assessment visit(s), we develop a specific plan of care (POC) for review and approval by your child's referring provider. Once your child's referring provider signs the (POC), we can begin working with your family to improve your child's condition. We are pleased to serve your Physical Therapy, Occupational Therapy, and/or Speech-Language Pathology needs and encourage your feedback to alert us to anything we can do to provide your child the highest quality of care.

We require certain information from each patient in order to begin providing care. The attached forms need to be completed in order for us to begin serving your child as our patient. Please do your best to complete all the information. If certain information does not apply to your child, please indicate that by noting "N/A" ("Not Applicable") so that we know that you did not overlook anything.

Each healthcare insurance payor has different guidelines for allowing coverage of Physical Therapy, Occupational Therapy, and/or Speech-Language Pathology services. It is helpful if you let us know your healthcare payor when starting service so that we may find out if prior authorizations are needed. If your child is a Medicaid beneficiary, please ask your primary care provider to send us a referral for your initial assessment to fulfill Medicaid requirements. If your healthcare insurance payor does not cover Physical Therapy, Occupational Therapy, and/or Speech-Language Pathology services, you are welcome to make self pay arrangements for the usual and customary pricing of our services.

ALASKA MEDICAID RECIPIENTS:

Alaska Medicaid requires that a physician, physician assistant, or advanced nurse practitioner refer you to our practice before we can perform an initial assessment on you. After we have completed your initial assessment, we develop an individualized POC to meet your specific therapy goals.

Your primary care practitioner will need to review and approve your POC, and then return it to our practice before we can begin your treatment.

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MEDICAID & PRIVATE INSURANCE
CO-PAYMENTS, DEDUCTIBLES, AND NON-COVERED SERVICE

Private insurance companies may have limits on the amount of Physical Therapy, Occupational Therapy, and/or Speech-Language Pathology services covered. Once you have exceeded the financial limit of your benefits and you do not have additional healthcare coverage, you are responsible for the payment of your child's services. Additionally, private healthcare insurance payors have deductibles and co-payments for physical therapy, occupational therapy, and/or speech language pathology services that are the responsibility of the patient.

While this practice will not discontinue your child's services for financial hardships, it is expected that patients pay at the time of service and/or set up payment arrangements.

COLLECTION OF PAST DUE ACCOUNTS

We communicate with our patients' parents/guardians to resolve past due accounts in all cases. If we cannot reach a patient's parent/guardian by phone following the return of undeliverable mail, or if a patient payment agreement cannot be made or paid as agreed, we are forced to use the services of a professional collection agency. Once an account is placed with a collection agency, we cannot take the account back. Please let us know when or if your patient contact information changes so that we can always reach you, if needed, to discuss past due accounts.

FINANCIAL AGREEMENT

New patients approved for Physical Therapy, Occupational Therapy, and/or Speech-Language Pathology services are responsible for any and all charges not paid for by healthcare insurance payors (Medicaid, private health insurance carriers, etc.). By signing this patient agreement, you are acknowledging that you understand this condition of service and commit to promptly paying All For Kids Pediatric Therapy for the services we provide to you, our valued customer. Following the receipt of your monthly patient statement, please contact our practice to make payment arrangements. We accept cash, personal checks, money orders, and credit cards (VISA, MasterCard, and Discover Card); we also make credit card pre-payment arrangements for anticipated monthly patient balances. We also are willing to make reasonable payment arrangements to keep your account current. Please contact our Billing Office at (907) 345-0050.

QUALITY ASSURANCE & COMPLAINT RESOLUTION

Should you or your child's caregiver experience a situation that requires the attention and resolution of a Supervisor and/or Manager, please contact our practice either in writing or by phone at (907) 345-0050. A member of our management team will interact with you to reach a resolution of any identified situation where our quality of service has been compromised. We use such situations to alert us to improvements we can make to better serve all our patients.

PATIENT STATEMENT OF AGREEMENT

My signature below signifies that I have read and understand this patient agreement for All For Kids Pediatric Therapy, LLC to provide me Physical Therapy, Occupational Therapy, and/or Speech-Language Pathology services. I agree to the terms in this patient agreement and intend to comply with them to the best of my ability. I understand that if I fail to follow the terms of this agreement, I could be discharged from service.

Parent/Legal Guardian Signature **Date**

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FINANCIAL POLICY

Payment, co-payment, deductibles, and co-insurance for services are due each visit for charges incurred up through your last visit. We accept cash, checks, VISA, MasterCard, and Discover Card. **Please understand that you are financially responsible for all charges, whether or not they are paid by insurance and that failure to abide by the financial policy will result in prompt removal from the schedule.**

Please read carefully and initial each statement:

_____ Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract. As a courtesy to our clients, we will bill your insurance carrier; however, we cannot guarantee payment in a timely manner. If for any reason any portion of a bill is not paid by your insurance within 60 days from the date of service, you agree to make arrangements for prompt payment.

_____ We require a credit card on file for each client. Any outstanding statement balance less than or equal to $200 will be automatically charged each month.

_____ Any accumulating balance over $200 requires immediate payment in full or a payment plan agreement on file. Payment plans require a monthly payment that includes a percentage of expected monthly accrued charges and a portion of any existing balance. All remaining unpaid charges are **due in full** by the end of the calendar year. Accounts that are not paid in full by the end of the year will be considered past due and charged 10.5% interest on the remaining balance.

_____ Any bill that is not paid within 90 days or put on a payment plan will be placed in a collections status and turned over to a collection agency. A $50.00 service charge will be added to all balances sent to collections.

_____ Should your insurance coverage change, our office should be notified within 30 days of the effective date and the card or stickers should be available for copying. If you fail to provide us this information, your account will be charged an insurance reprocessing fee of $100. Any claims that are unable to be reprocessed will be your financial responsibility in full.

_____ Our fees are generally considered to fall within the acceptable range by most insurance carriers and therefore are covered up to the maximum allowance determined by each carrier. This applies to the companies who pay a percentage (such as 50% or 80%) of the usual, customary, and reasonable rate (UCR). This statement does not apply to companies who reimburse based on an arbitrary schedule of fees, which bears no relationship to the current standard and cost of care in this area.

_____ Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. These particular services, if any, are your responsibility. **Please note insurance companies may indicate the services were not medically necessary and claim that, because All For Kids is a preferred provider, you do not have to pay the balance. This is NOT the case and you will be billed for the services.** This office cannot accept responsibility for negotiating settlements on disputed claims.

_____ Any returned checks or denied credit card on a payment plan will be subject to a non-sufficient funds (NSF) fee of $25.00.

Please initial the following statements:

_____ I have checked with my insurance company prior to this therapy visit and assert that I have obtained the necessary information regarding limits of coverage, co-pays, and co-insurance.

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_____ I give All For Kids Pediatric Therapy, LLC permission to submit bills directly to the insurance carrier.

I hereby understand the above financial policy and agree to abide by it.

_____ _____
Parent/Legal Guardian Signature Date

Credit Card Authorization
My signature below indicates I agree to the terms above and authorize All For Kids to charge my credit/debit card as agreed upon above. I understand that my information will be saved in a secure online system for future transactions on my account and that this authorization will remain in effect until I cancel it in writing. I certify that I am the authorized user of the provided card and will not dispute these scheduled transactions; so long as the transactions correspond to the terms indicated in this authorized form.

_____ _____
Cardholder Signature Date

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CANCELLATION POLICY

As a courtesy, please call our office within 24 hours of a scheduled appointment if you need to cancel or reschedule that appointment. For Monday morning appointments, our office appreciates being notified no later than Friday noontime. If therapy needs to be canceled for an extended length of time (for example, due to vacation, insurance problem, etc.), management will discuss and approve holds on a case-by-case basis.

Please read carefully and initial each statement:

_____ I understand it is my responsibility to communicate any schedule changes or appointment cancellations **to the front desk**. Scheduling changes/cancellations should not be done with therapists and fees will still apply if the front desk is not alerted.

_____ If a therapy session is not canceled 90 mins prior to an appointment time or is missed without any notice, this missed appointment is counted as a no-show which will result in a charge of a $50.00 no-show fee. No-shows to an initial evaluation will result in a charge of a $100.00 no-show fee. **Note: Insurance companies DO NOT reimburse for late fees; this is the responsibility of the parent(s)/guardian.**

_____ If a session is delayed 8 or more minutes due to late arrival of the client, the parent(s)/guardian will be charged a $10.00 late fee. **Note: Insurance companies DO NOT reimburse for late fees; this is the responsibility of the parent(s)/guardian.**

_____ If a parent/guardian is more than 5 minutes late to pick their child up, the parent(s)/guardian will be charged $1 for every minute they are late (e.g., You will be charged $6 on the 6th minute of being late, etc.). **Note: Insurance companies DO NOT reimburse for late fees; this is the responsibility of the parent(s)/guardian.**

_____ Two consecutive no-shows may require your child to be placed on a hold status until the issue of missed appointments is resolved. If a resolution is not made within two days, your child will lose his/her therapy spot and be placed on our information list. Excessive no-shows may also result in removal from the schedule.

_____ We require an 80% attendance rate and may need to remove the client from the therapist's schedule if efforts are not made to maintain this rate. Note: We calculate attendance quarterly and, as a courtesy, will notify you if your percentage drops below the required 80%.

I hereby understand the above cancellation policy and agree to abide by it.

_____ _____

Parent/Legal Guardian Signature Date

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CLINIC ETIQUETTE

Once again, we welcome you to All for Kids Pediatric Therapy. We are honored that you have chosen our clinic to meet the needs of your child and your family. We continually try to create a space and an atmosphere that is true to our name – fun and inviting for kids and their families. We hope that you are comfortable here and always feel welcome. Please know that you can approach us with any comments or concerns regarding our space and how it is used. In order to make All for Kids a comfortable and safe place for all of our families and our staff, we ask that families follow our clinic etiquette plan. Please read and become familiar with the following expectations.

Please adhere to the following steps when coming to therapy:

- If you are a new patient, please come in and check in with the front desk and wait inside for your therapist.
- If you are an existing patient, please wait in your car and call the front desk at 907-345-0050 to check in. After you call to check in, walk your child into the building no earlier than 5 minutes before their appointment and wait in our transition zone. Help your child remove their shoes and coat to have them ready for therapy. Once your child transitions to the therapist, return to your car to wait.
- Come back into the building to pick up your child no earlier than 5 minutes before the end of the appointment time. Parents/caregivers must be timely to pick up in order to avoid late pickups, provide adequate time for session debriefing, and to help our therapists be on time to their next client.

Please note the following clinic etiquette expectations:

- Please make arrangements to attend your child's therapy session when requested by the therapist. We also welcome parent requests to join treatment sessions. Active parent participation in the therapy process is critical for progress and carryover of new skills. Let your child's therapist know if you would like to participate in a session. If siblings will be observing and/or participating, it should be with permission from the therapist.
- If parents are in attendance at sessions, please remove your shoes per our clinic policy. There is space near the front desk window to leave shoes as well as coats/jackets.
- Do not enter the treatment space without a clinic escort.
- Accompany all younger children and those needing assistance or supervision to the restroom; this includes using the restroom for hand washing.
- If you have children in diapers or pull-ups, please bring a diaper bag to therapy and be prepared to change your child if necessary.
- We discourage bringing toys from home to treatment sessions unless your therapist requests them or gives permission to bring them. Your therapist will choose toys from our clinic with a specific therapeutic purpose.
- If you are observing your child's treatment session, remain in the same room as your child and their therapist. In order to protect the confidentiality of all children in our clinic, please do not leave the treatment room unless accompanied by your therapist or exiting the building.
- Please keep cell phone and tablet use to a minimum in treatment areas and place phones on vibrate or silent.
- Please be mindful of the content discussed in your conversations (phone or in-person) or viewed on your electronic devices while in the clinic. Please only discuss topics or select websites, videos, music, etc. which are appropriate to discuss/view in the presence of children.

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- Please do not ask therapists about other clients or families at the clinic. In order to comply with HIPAA, we cannot answer these questions.
- Be respectful of the 'end of session' time. Your therapist typically has less than 5 minutes to talk to you about the session. In most cases, there is another family waiting to begin therapy. If you need additional time to discuss a concern, ask questions, or problem-solve treatment activities, please join your child's session or arrange for an alternative time to discuss those topics with your child's therapist.
- Do not send your child to therapy if they have a fever. Keep your child home until they are fever-free for 24 hours without medication and symptoms are improving. If you need to cancel due to illness, rescheduling your appointment whenever possible is encouraged to maintain your child's progress and attendance. For any other questions about AFK's illness policy, please contact the front desk.

As your team of therapists, you can expect us to:

- Begin and end your appointments in a timely manner.
- Inform you of the goals targeted and the progress made during each session.
- Provide strategies and ways for you to address goals at home to increase carryover.
- Assist you in any way we can, such as brainstorming ideas to help make your family's life easier at home or talking with school therapists, etc.
- Keep anything you share with us confidential.
- Provide the best therapy we possibly can.
- Receive courteous and friendly help when scheduling appointments or dealing with billing questions.

If you have any questions about the above information, please do not hesitate to ask us.
We are here to help you!

I have read and understand the above Clinic Etiquette and agree to abide by it.

_____ _____
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ALL FOR KIDS PEDIATRIC THERAPY
SCOPE OF PRACTICE

Persons Served:
Children age from birth to adolescence. New clients 14-18 years of age are seen on a case by case basis.

Medical Acuity & Medical Stability:
Children must be healthy and cleared for treatment by their physician. Children may not attend therapy if they have potentially contagious illnesses, including but not limited to:

- Fever of 100.4 or greater
- Pink eye
- Vomiting and/or diarrhea
- Hand-foot-mouth disease
- Lice

Settings, Hours, and Days of Service:
Therapy services are provided between the hours of 7 AM and 6 PM, Monday through Friday, at our clinic located at 6927 Old Seward Highway, Suite 100. Therapy is provided in an outpatient setting at the YMCA Dimond Pool for aquatic therapy and the Chamberlin Equestrian Center for hippotherapy.

Admission Criteria:
Your child's evaluation with your therapist will determine the need for therapeutic intervention, typically on a weekly, ongoing basis until criteria for discharge is achieved. Your child may be referred to another agency or for a different service depending on the recommendations of the evaluation and our clinic's ability to adequately meet their needs.

Discharge Criteria:
AFK may discharge a client for the following reasons:

- Client has completed the plan of care and no further concerns are identified
- Client is 18 years of age
- Client no longer demonstrates a need for intervention
- Client has plateaued and is not benefitting from continued services
- Client is not meeting financial responsibilities to AFK
- Client is not meeting the required attendance
- At the request of the caregiver
- At the discretion of AFK management for any other reasons (e.g., safety within the clinic)

Your Therapist:
A therapeutic match with your therapist is important. If a personality conflict arises that interferes with the therapeutic match between your child/family, please speak with your therapist directly or a member of the management team to inquire about switching therapists.

When your therapist is out of the office, your child may have coverage with a substitute therapist. Substitute therapists make every effort to make sessions as fun and productive as when your child sees their regular therapist. These visits bring a positive opportunity for your child to practice their skills with a new person and bring a different perspective to your child's treatment.