Sandia Sunrise Therapy
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Patient Name: _____
Date of Birth: _____

NEW PATIENT INTAKE FORM

PERSONAL INFORMATION:

Child's Legal Name: _____ Date of Birth: _____
Age: _____ Male: _____ Female: _____ Primary Care/Pediatrician: _____

Legal Guardian: _____ Legal Guardian: _____
Date of Birth: _____ Date of Birth: _____

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: _____ ☐ ☐

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: _____

Which Physician/Doctor 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 **DO NOT** HAVE ANY OTHER INSURANCE COVERAGE FROM ANY OTHER SOURCE OTHER THAT THE ABOVE MENTIONED.

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EMERGENCY MEDICAL RELEASE:

In the event medical attention is required for your child while in the premises of Sandia Sunrise Therapy LLC, we need your authorization to implement treatment. Please read and sign the statement below.

As legal guardian of _____, I give my permission for Sandia Sunrise Therapy LLC to contact emergency personnel in the event of a medical emergency.

_____ _____
Parent/Legal Guardian Signature Date

EMERGENCY CONTACT:

NAME: _____ PHONE: _____

RELATIONSHIP: _____

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, website, and/or social media.

TECHNOLOGY PERMISSION:

Please **initial** the following OPTIONAL statements:

_____ **EMAIL:** I give permission to Sandia Sunrise Therapy LLC (SST) to correspond with my child's legal guardians and care team via e-mail regarding treatment, documentation, and home programming. I understand that SST e-mail is encrypted internally; however once an email is sent externally, correspondence may potentially be intercepted by an outside party.

_____ **TEXT:** I authorize Sandia Sunrise Therapy LLC (SST) 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 SST. I agree not to hold SST liable for any electronic messaging charges or fees generated by this service. I understand that SST text messages to my cell phone are not secure and potentially could be intercepted by an outside party.

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AUTHORIZATION AND CONSENT FOR EVALUATION, TREATMENT, AND OPERATIONS:

Please **initial** the following statements:

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

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

ADDITIONAL SERVICES:

List the names of the programs/people that work with your child outside of Sandia Sunrise Therapy LLC.

Service	Practice/School Name	Provider Name	Last Seen
Pediatrician/Physician			
Child Care Program			
Preschool/School			
Occupational Therapist			
Speech Therapist			
Physical Therapist			
Counselor/Psychologist			
Early Intervention			
Caseworker/Care Coordinator			
Dietitian/Nutritionist			
Specialty Doctor			
Other			

I hereby authorize any prior or present treating physician, therapist, school, hospital, or other health institution, to release all of medical information by any means of communication to Sandia Sunrise Therapy LLC.

_____ _____
Parent/Legal Guardian Signature Date

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If your child has an IEP through his/her school, please bring us a copy for our records.
If your child has a Neuropsychological Evaluation or any additional testing, please bring us a copy for our records.

DEVELOPMENTAL/ MEDICAL HISTORY FORM:

Allergies: _____	Current Medications (Name/Dosage): _____
Siblings (Name/Age): _____ _____ _____ _____	Languages spoken at home: English ☐ Spanish ☐ Other: _____
Has your child ever been diagnosed by a doctor or psychologist with a developmental, behavioral disorder, or other medical diagnosis? *Please check any of the following diagnoses that apply to your child:* Autism ☐ ADHD ☐ Cerebral Palsy ☐ Anxiety ☐ Asthma ☐ Constipation ☐ CVI ☐ Sleep Apnea ☐ Reflux ☐ Syndrome: _____ Other: _____	
Has anyone (teacher, pediatrician, friend, relative) suggested your child be evaluated for a specific diagnosis? *Please check the answer that applies:* Yes ☐ No ☐	If yes, what diagnosis? _____ _____

BIRTH HISTORY:

Please check those that apply and/or write in answers

Any difficulties during pregnancy? Bed rest ☐ Gestational Diabetes ☐ Pre-eclampsia ☐ Other: _____			Any difficulties during labor?
Length of Pregnancy: wks	Birth was: Vaginal ☐ Caesarian ☐	Length of Labor: hrs	Labor was: Normal ☐ Induced ☐
Birth Weight: lbs oz	Duration of hospital stay post birth:		NICU Stay: Yes ☐ No ☐
Any problems with the following: Jaundice ☐ Colic ☐ Reflux ☐ Feeding ☐ Head Shape/Tilt ☐ Respiratory ☑ Other: _____			

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GENERAL MEDICAL HISTORY:

Please indicate if your child has experienced the following and specify if yes

Has your child ever been hospitalized?	Yes☐ No☐	If yes please explain and give age at hospitalization:		
Seizures	Yes☐ No☐	If yes date of first seizure:	Current frequency of seizures:	Seizure Triggers:
Respiratory or lung difficulties	Yes☐ No☐	Specify If Yes:		
Ear Infections	Yes☐ No☐	Specify If Yes:		Tubes? Yes☐ No☐
Cardiac Problems	Yes☐ No☐	Specify If Yes:		
Hip Dysplasia	Yes☐ No☐	Specify If Yes:		
Surgery	Yes☐ No☐	Specify If Yes:		
Sleep Difficulties	Yes☐ No☐	Specify If Yes:		
Poor Weight Gain	Yes☐ No☐	Specify If Yes:		
Hearing Problems	Yes☐ No☐	Specify If Yes:		Date of last hearing check:
Vision Problems	Yes☐ No☐	Specify If Yes:		Date of last vision check:
Dizziness/ Headaches	Yes☐ No☐	Specify If Yes:		
X-ray	Yes☐ No☐	Specify If Yes:		
MRI	Yes☐ No☐	Specify If Yes:		
CT Scan	Yes☐ No☐	Specify If Yes:		
Genetic Screen	Yes☐ No☐	Specify If Yes:		
EEG	Yes☐ No☐	Specify If Yes:		

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DEVELOPMENTAL HISTORY:

Please indicate whether your child performed the following skills and indicate approximate age if known

Gross motor skills	Yes/No	Age skill achieved	Comments
Rolling			
Sitting			
Crawling			
Standing			
Walking			

EDUCATIONAL HISTORY:

Please check those that apply and/or write in answers

Is your child currently enrolled in school/ daycare/preschool? Yes ☐ No ☐	If yes list name of program/school:	Grade Level:

Does your child receive any of the following services at school?

Occupation Therapy ☐ Physical Therapy ☐ Speech Therapy ☐

Other:_____

Is your child involved in any structured after school/weekend programs (i.e. gymnastics, swimming, soccer, YMCA)?

_____
_____
_____

OTHER:

Is there anything else you would like to share about your child's medical/developmental history that was not listed above? Yes ☐ No ☐	Specify If Yes: _____ _____ _____ _____

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PATIENT AGREEMENT:

Please carefully read and review the following policies

MEDICAID & PRIVATE INSURANCE CO-PAYMENTS, DEDUCTIBLES, AND NON-COVERED SERVICE:
Insurance companies may have limits on the amount of Physical and/or Occupational Therapy services covered. Once you have exhausted the limit of your benefits and you do not have additional healthcare coverage, you are responsible for the payment of these services. While this practice will not discontinue your services for financial hardships, it is expected that patients pay at the time of service and/or set up payment arrangements.

Should your insurance coverage change, our office must be notified within 30 days of the effective date. If you fail to provide us this information, your account and future balances will be your responsibility. We will no longer bill insurance and you will be responsible for submitting claims to your insurance carrier. Payment will be due at time of service in full.

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 Sandia Sunrise Therapy LLC 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.

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.

_____ I give Sandia Sunrise Therapy LLC permission to submit bills directly to the insurance carrier.

COLLECTION OF PAST DUE ACCOUNTS:
We communicate with our patients to resolve past due accounts in all cases. If we cannot reach a patient 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 and Occupational Therapy 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 Sandia Sunrise Therapy LLC for the services we provide to you, our valued customer. We accept cash, personal checks, and credit cards (VISA, MasterCard, and Discover Card). ***Any returned checks will be subject to a NSF fee of $25.00 which will be due at the next visit. Accounts that are past due will incur a finance charge at the rate of 18% annually.*** We also are willing to make reasonable payment arrangements to keep your account current. If arrangements are needed, please contact our Billing Office.

PATIENT STATEMENT OF AGREEMENT:
My signature below signifies that I have read and understand this patient agreement for Sandia Sunrise Therapy LLC to provide me Physical and/or Occupational Therapy 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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CANCELLATION POLICY

Our clinic strives to provide the best therapy services possible. In order to ensure optimal use of valuable therapy time, ***please discuss schedule changes at the end of your appointment with your therapist and the front desk***. We understand occasional changes are necessary due to illness, vacations, etc. Please call our office within 24 hours of a scheduled appointment if you need to cancel or reschedule an appointment. This allows for patients to reschedule into additional openings therapists may have. For Monday morning appointments, our office appreciates being notified no later than Friday noontime.

Please review and initial all statements below:

_____ I understand it is my responsibility to communicate to the front desk any schedule changes or appointment cancellations.

_____ If a therapy session is not canceled 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. ***Note: Insurance companies DO NOT reimburse for no-show fees; this is the responsibility of the patient.***

_____ Three consecutive no-shows may require your child to be taken off the schedule and placed back on the waitlist.

_____ We require an 80% attendance rate and may need to remove the patient 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%.

We are happy to work out scheduling problems with you. Please let us know if you are experiencing a problem with your current schedule. If therapy needs to be canceled for more than three weeks, (such as for an extended trip), we will place you back on the waitlist and will fit you back in the schedule as soon as we can.

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

_____ Parent/Legal Guardian Signature

_____ Date

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LEARN.PLAY.GROW

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CLINIC ETIQUETTE

In order to make Sandia Sunrise Therapy LLC a comfortable and safe place for all of our families and our staff, we ask that families follow our clinic etiquette plan. Please acknowledge the following requests:

1. Please check in at the front desk and wait for your therapist to accompany you and/or your child to the treatment area to allow for patient confidentiality and compliance with HIPAA policies.
2. When joining a session after it has started please check in with the front desk first.
3. To ensure the safety of your child and others please monitor your children and do not allow them to climb on, jump from, or disassemble the waiting room furniture or toys.
4. Please clean up after your children in the waiting room. Help them replace any books or toys they may have used and throw away any trash that may have accumulated.
5. Accompany all younger children and those needing assistance or supervision to the restroom; this includes using the restroom for hand washing.
6. 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.
7. The family is always invited to attend your child's treatment session. However, please do not allow siblings to play on or with equipment, unless invited by the therapist. Please provide any siblings attending therapy with their own activities.
8. 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.
9. If you are observing your child's treatment session, remain with your child and therapist until the end of session. In order to protect the confidentiality of all children in our clinic, we ask that if you need to leave the treatment room for any reason, you return to the waiting room and wait for the session to end.
10. Please keep electronic use to a minimum in all areas and place phones on vibrate or silent. Cell phone and tablet use is acceptable in the common areas, but please keep phone conversations brief and use headphones if watching videos or listening to music. Please take extended phone conversations outside the building.
11. In order to comply with HIPAA, please do not ask therapists about other patients or families at the clinic.
12. Be respectful of the 'end of session' time, please be ready to pick-up your child and speak with your therapist at 10 till the hour.
13. Due to the number of children we treat with allergies and restricted diets, we ask that no outside food be taken beyond the waiting room. If your therapist needs to incorporate food into the treatment session, they may request that you bring specific foods to your session. Please also clean up any food messes that occur as quickly as possible to avoid accidental ingestion by other patients.

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

1. Begin and end your appointments in a timely manner.
2. Inform you of the goals targeted and the progress made during each session.
3. Provide strategies and ways for you to address goals at home to increase carryover.
4. Assist you in any way we can (brainstorming ideas for home or talking with school therapists, etc.)
5. Keep anything you share with us confidential.
6. Provide the highest standard of care.
7. Provide courteous and friendly help when scheduling appointments or dealing with billing questions.

Please don't hesitate to ask us if you have any questions about the above information. We are here to help you!

I hereby understand the above clinic etiquette and agree to abide by it.

_____ _____
Parent/Legal Guardian Signature Date