ALASKA PEDIATRIC THERAPY

PATIENT INTAKE FORM

Child's name: _____Date of Birth:_____

Address:_____ State:_____ City:_____ Zip Code: _____

Preferred contact phone number(s): (_____)_____- _____ or (_____)_____- _____

Child resides with:_____

- Parent/Guardian:_____ Contact info same as patient ☐ yes ☐ no

Address (if different from patient): _____ State:_____ City:_____ Zip Code: _____

Home # (_____)_____- _____ Cell # (_____)_____- _____ Work # (_____)_____- _____

Email:_____ Appointment Reminder: ☐ Text ☐ Email

- Parent/Guardian:_____ Contact info same as patient ☐ yes ☐ no

Address (if different from patient):_____ State:_____ City:_____ Zip Code: _____

Home # (_____)_____- _____ Cell # (_____)_____- _____ Work # (_____)_____- _____

Email:_____ Appointment Reminder: ☐ Text ☐ Email

PEDIATRICIAN/PHYSICIAN:

Name:_____ Phone:(_____)_____- _____

EMERGENCY CONTACT INFORMATION:

Name:_____ Phone: (___)_____- _____ Relationship to child:_____

DIGNOSIS: Please list all medical diagnoses or conditions: _____

_____

Primary concerns regarding your child: _____

_____

_____

MEDICATION: Please list all medication your child is currently taking, including prescription, nonprescription, vitamins, and homeopathic substances. _____

_____

ALLERGIES: _____

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EMERGENCY MEDICAL RELEASE:

In the event that medical attention is required for your child while on the premises of APT, LLC, we need authorization to implement treatment. As legal guardian of _____, I give my permission for APT to contact emergency personnel in the event of a medical emergency.

Signature: _____ Date: _____

INSURANCE INFORMATION:

- Primary Insurance:_____ Insured Name:_____

Policy #:_____ Group #_____

Insured DOB:_____ Insured SSN:_____

- Secondary Insurance:_____ Insured Name:_____

Policy #:_____ Group #_____

Insured DOB:_____ Insured SSN:_____

- Tertiary coverage:_____ Insured Name:_____

Policy #:_____ Group #_____

Insured DOB:_____ Insured SSN:_____

I give Alaska Pediatric Therapy, LLC permission to submit bills directly to the insurance carrier. I authorize payment of insurance benefits directly to Alaska Pediatric Therapy, LLC. I guarantee that my insurance covers therapy services. I agree to pay my portion of the insurance deductible directly to Alaska Pediatric Therapy, LLC. Should collections become necessary, I agree to pay all collection agency fees.

Signature: _____ Date: _____

PHOTO PERMISSION:

-I give permission for the photograph/video of my child to be used for the purpose of treatment, education, and documentation. Initials: _____ Date: _____

-I give permission for the photograph/video of my child to be utilized for brochures, advertising, and/or website.

Initials: _____ Date: _____

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CANCELLATION/NO SHOW POLICY

We appreciate the opportunity to provide excellent therapy services to your child. To maintain our high standards and commitment to excellence to your family as well as other families, we believe that consistency of care is very important. In order to make our therapists more available for your child's needs as well as the needs of others, we have the following cancellation/no-show policy. Please take a moment to read and become familiar with this policy.

- **If a therapy session is cancelled within 6 hours of the appointment time, or is missed without any notice, this missed appointment is counted as a no-show, which will result in a charge of $15.** ***Note: Insurance companies DO NOT reimburse late/no-show fees; this is the responsibility of the parent/guardian.*
  _____ **Initials**

- 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 will be placed on the waiting list.
  _____ **Initials**

- Patients who arrive more then 15 minutes past the scheduled start time of the appointment will be charged a $15 late fee. We understand that inclement weather, road construction and special circumstances related to your schedule & child's needs may effect travel times so please plan accordingly. ***Note: Insurance companies DO NOT reimburse late/no-show fees; this is the responsibility of the parent/guardian.*
  _____ **Initials**

- We require a 75% attendance rate for all scheduled appointments. If the therapist's schedule is not adhered to, the client will be taken off of the schedule. As a courtesy, we will track all visit numbers, and notify you if your percentage falls below the required 75%.
  _____ **Initials**

Signature: _____ Date: _____