**New Patient Intake Form**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CHILD INFORMATION | | | | | | PARENT/GUARDIAN INFORMATION | | | | | | |
| **Name** |  | | | | | **Mother** |  | | | | | |
| Date of birth |  | | Age | |  | DOB |  | | | Home Ph | |  |
| Gender |  | | Doctor | |  | Cell Ph |  | | | Work Ph | |  |
| Person Referring | | |  | | | *Mailing Address* | |  | | | | |
| Medical Diagnosis | | |  | | | City, State, Zip | |  | | | | |
| Current immunizations? | | | Yes ☐ No ☐ | | | *Physical Address* | |  | | | | |
| If “NO” give reason | | |  | | | City, State, Zip | |  | | | | |
| Child resides with? | | | Parents ☐ Foster☐ | | | Occupation | |  | | | | |
| Who has custody of child? | | | Parents ☐ OCS ☐ | | | Employer | |  | | | | |
| *OCS Caseworker.* | | | Name |  | | **Father** |  | | | | | |
| Cell |  | | DOB |  | | | Home Ph | |  |
| *Person other than parent bringing child to therapy.* | | | Name |  | | Cell Ph |  | | | Work Ph | |  |
| Cell |  | | *Mailing Address* | |  | | | | |
| PRIMARY INSURANCE INFORMATION | | | | | | City, State, Zip | |  | | | | |
| Primary Insurance | |  | | | | *Physical Address* | |  | | | | |
| Policy Number | |  | | | | City, State, Zip | |  | | | | |
| Group Number | |  | | | | Occupation | |  | | | | |
| Expiration | |  | | | | Employer | |  | | | | |
| Claims Address | |  | | | | ***May we send out an appointment reminder via text or email?* ☐** Yes **☐** No  **☐** Text Cell ph #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **☐** Email Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **☐** Both  ***May we email requested medical records to you?***  **☐** Yes **☐** No Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **☐** I authorize AKT, KKT, and/or ORS to submit bills directly to the insurance carrier(s) for payment.  **☐** I authorize insurance carrier(s) to make payments to AKT, KKT, and/or ORS.  **☐** I understand that KKT and/or ORS may be billing the Infant Learning Program (ILP) for my child while enrolled in ILP. Once my child is discharged from ILP, I hereby give KKT and/or ORS permission to bill my insurance carrier(s) directly for payment. | | | | | | |
| Phone Number | |  | | | |
| Insured’s Name | |  | | | |
| Insured’s DOB | |  | | | |
| SECONDARY INSURANCE INFORMATION | | | | | |
| Secondary Insurance | |  | | | |
| Policy Number | |  | | | |
| Group Number | |  | | | |
| Expiration | |  | | | |
| Claims Address | |  | | | |
| Phone Number | |  | | | |
| Insured’s Name | |  | | | |
| Insured’s DOB | |  | | | |
| **Parent or Legal Guardian Signature** | | |  | | | | | | **Date** | |  | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of Child** | | | | | | | | | |
| List all the names of providers and programs that have worked with or are currently providing services to your child.  *\* Physicians, teachers, therapists, day care, counselor, etc.* | | | | | | | | | |
| **Name of Provider and Program** | | | | **Phone Number** | | | **Dates** | | |
|  | | | |  | | |  | | |
|  | | | |  | | |  | | |
|  | | | |  | | |  | | |
|  | | | |  | | |  | | |
| PERMISSIONS | | | | | | | | | |
| **☐** I give permission for students/shadows to observe my child for the purpose of education. | | | | | | | | | |
| **☐** I give permission to photograph/videotape my child for the purposes of treatment, education, and/or documentation. | | | | **☐** I give permission to photograph/videotape my child to be used for advertising, brochure, and/or web space. | | | | | |
| Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA) | | | | | | | | | |
| **☐** I acknowledge that I have viewed and been offered a copy of the Notice of Privacy Practices. | | | | | | | | | |
| EMERGENCY CONTACT NAME (other than self) | | | | | | | | | |
| Name |  | | Relationship |  | Phone Number | | | |  |
| Name |  | | Relationship |  | Phone Number | | | |  |
| EMERGENCY MEDICAL RELEASE | | | | | | | | | |
| **☐**As legal guardian of this child, I give my permission for AKT, KKT, and ORS, in the event medical attention is required for your child while on the premises of AKT, KKT, and ORS to provide basic life support medical treatment and/or to contact emergency personnel in the event of a medical emergency. | | | | | | | | | |
| EVALUATION CONSENT | | | | | | | | | |
| During the evaluation the therapist may assess your child’s abilities in one or more of the following areas: communication, social, play, problem solving, sensory, motor, body structures. The evaluating therapist may use one or more of the following procedures: caregiver interview, medical record review, clinical observation, developmental tests, body structure exam. Minor risks may include irritability, fatigue, and/or tired muscles.  **☐**Igive consent for my child to be evaluated today. | | | | | | | | | |
| TREATMENT CONSENT | | | | | | | | | |
| Following evaluation the therapist will review the findings with you and recommend treatment interventions for your child. Therapeutic interventions in one or more of the following areas may include: education, home program, communication, language, social, play, daily living activities, sensory, motor, exercise, positioning, taping, orthotics, equipment fitting. Minor treatment risks may include irritability, fatigue, and/or tired muscles.  **☐**If treatment is recommended Igive consent for my child to receive the agreed upon therapeutic interventions. | | | | | | | | | |
| **Parent or Legal Guardian Signature** | |  | | | | **Date** | |  | |