**New Patient Intake Form**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 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 unencrypted email?* ☐** Yes **☐** No  **☐** Text Cell ph #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **☐** Email Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **☐** Both  ***May we email (not encrypted) requested medical records or therapist communication 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** | | |
|  | | | |  | | |  | | |
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| 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.  *HIPAA/Policy booklet available in waiting room or ask receptionist to see a copy.* | | | | | | | | | |
| 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** | |  | |

**Alaska kids talk, llc – kenai kids therapy, inC – occupational rehab services, Inc**

**Notice of Privacy PractiCES**

**Effective january 1, 2015**

**This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get AcCESS To This Information. Please Review It Carefully.**

OHCA Designation

The HIPAA Privacy Regulations allow Covered Entities who participate in an organized health care arrangement or “OHCA” to comply with the HIPAA Notice requirements by the issuance of a joint notice. One type of an OHCA is a clinically integrated care setting where individuals receive health care from more than one health care provider. Alaska Kids Talk, LLC (AKT), Kenai Kids Therapy, Inc. (KKT), and Occupational Rehab Services, Inc. (ORS) are an OHCA. We may disclose and share protected health information with the various staff members and other individuals participating in the OHCA as necessary to carry out treatment, payment, or other health care operations. “We,” “us,” and “our” in this Notice refers to each company and all the staff members of those companies, and the privacy, security, and breach notification obligations of HIPAA are carried out jointly by all three companies.

This Notice describes the medical information practices of AKT, KKT, and ORS. AKT, KKT, and ORS are considered a covered entity, and therefore we are required by law to maintain the privacy of personal health information and to provide you with notice of our legal duties and privacy practices with respect to personal health information. All AKT, KKT, and ORS departments or programs are covered by this Notice and your personal health information may be shared among these divisions.

**Our Pledge Regarding Medical Information**

We understand that medical information about your health is personal. We will not disclose your personal health information to others unless you tell us to do so, or unless the law authorizes or requires us to do so. This Notice applies to all of the medical records we maintain. It describes the ways in which we may use and disclose medical information, and describes our obligations with regard to such information.

We are required by law to:

• Keep your protected health information private;

• Provide notice of our legal duties and privacy practices with respect to protected health information;

• Notify affected individuals following a breach of unsecured protected health information;

• Give you this Notice of Privacy Practices; and

• Follow the terms of the Notice of Privacy Practices currently in effect.

Due to the open space nature of our practice with therapists providing services to children in halls and shared treatment rooms as well as communicating with you in the waiting room we may inadvertently share information about your child’s health care that may be unintentionally overheard. We actively seek to minimize inadvertent disclosures and appreciate your assistance in discussing your child’s health care in private. Providers may ask to speak with you about your child in a private room rather than the waiting room prior to or following therapy sessions. You may be asked to sign a confidentiality form should you inadvertently overhear discussion regarding another patient.

We have the right to change our practices regarding the personal health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of the Notice by calling the Privacy Officer at 907-260-7444 or stopping by the Privacy Officer’s office at:

Kenai Kids Therapy

35105 Kenai Spur Highway, Ste. A

Soldotna, AK 99669

*\* HIPAA/Policy booklet available in waiting room or ask receptionist to see a copy.\**