



Therapy Group of Tucson, PLLC

2260 N. Rosemont Drive, Ste. 100

Tucson AZ 85712

Phone: (520) 232-2021

Fax: (520) 232-2553

DEMOGRAPHICS

Name:	Age:	Sex: <input type="checkbox"/> male <input type="checkbox"/> female
Social Security #: - -	Date of Birth:	
Street Address:		
City:	State:	Zip Code:
Marital Status : <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Domestic Partner		
Home Phone:	Cell Phone:	
Emergency Contact Name:	Telephone Number:	

Employer Name:	Occupation:
Employer Address:	
City:	State: Zip Code:
Business Phone: ()	
Are you currently working?	If not, last date worked:

Referred By:	Phone: ()
Address:	
City:	State: Zip Code:

PRIMARY INSURANCE INFORMATION

NO INSURANCE (SELF PAY → SEE OUT OF NETWORK/FINANCIAL PRIVATE PAY SECTION FORM)

Insurance Carrier:		
Address:		
City:	State:	Zip Code:
Policy/ Claim #:	Group/ WCB#:	
Adjuster:	Tel:	Fax:
Relationship to insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Other _____		
Insured's Name (if applicable):		
SS No.	DOB:	

SECONDARY INSURANCE INFORMATION

Insurance Carrier:		
Address:		
City:	State:	Zip Code:
Policy/ Claim #:	Group/ WCB#:	
Adjuster:	Tel:	Fax:
Relationship to insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Other _____		
Insured's Name (if applicable):		
SS No.	DOB:	



Important Company Policies for a Successful Relationship

We strive to provide you the best personalized care available. To make this possible we adhere to a set of very important guidelines. Please read them carefully, initial all the boxes, and indicate your agreement by signing/dating on the bottom of this form.

Initial
All
Boxes

Late Policy

Regardless of your arrival time, your appointment time will not change. We do not allow appointment overlap because this compromises the care of another patient.

48-Hour Advance Notice Fee

If you wish to change or cancel an appointment we require a minimum **48-hour advance notice**. Anything less will result in a **\$20 fee** charged to your account. This fee is waived only if the appointment is rescheduled within the same week or a valid Doctor's note is provided.

Copays are due upon arrival

Copays/deductibles/coinsurances are due at time of service. No exceptions. Be advised that you may be balance billed for services not covered by insurance. Non covered services are billed at 45.00 (30 minute appointment) and 60.00 (60 minute appointments).

No-shows are bad

If you fail to show for an appointment without notice all future appointments will be removed and a \$45.00 fee assessed to your account. You may re-schedule appointments again on a "first come, first serve basis."

Do not leave the premises while your child attends therapy

You are not allowed to drop your child off for therapy services and leave the premises for any reason. If there is an emergency and the parent is not present, we will call 911.

Financial Hardship

If you are experiencing financial difficulties and are unable to afford the cost of our services, please speak to us. We have financial options that may be helpful for you. If you qualify for financial assistance according to the Federal guidelines, we may be able to assist you by waiving or discounting your (patient responsibility) portions of the bill.

Insurance Billing and Payment

As a courtesy to you, Therapy Group of Tucson, PLLC will bill your therapy services to your insurance company. Be advised that a prior authorization is not a guarantee of payment. If your charges are applied to deductible, you will be billed that amount. You may be balance-billed the difference between your copay and the cost of the session. **Non covered services are billed at \$210.00 for Evaluation and \$85.00 for Therapy.**

We look forward to building a successful relationship with that lasts a lifetime!

Parent/Guardian Signature _____

Date: _____

Child's Name: _____

DOB: ___/___/___

Diagnosis: _____

Is child: ___biological ___adopted ___foster

PRENATAL HISTORY

NO YES Was there any difficulty during pregnancy? _____

NO YES Did mother take any medication and/or drugs during pregnancy? _____

NO YES Did mother smoke or consume alcohol during pregnancy? _____

NO YES Was there any difficulty during delivery? _____

NO YES Premature Birth? _____

NO YES NICU? _____

Type of birth: ___Vaginal ___Caesarian

MEDICAL HISTORY

Has your child had any of the following (if yes indicate date and/or what occurred)?

NO YES Chronic ear infections _____

NO YES Tubes in ears _____

NO YES Difficulty passing urine/stool _____

NO YES Coordination problems _____

NO YES Asthma _____

NO YES Wears glasses _____

NO YES Frequent colds and/or infections _____

NO YES Does your child take any medication _____

NO YES Unusual illnesses _____

NO YES Serious accidents _____

NO YES Surgery/hospitalization _____

NO YES Seizures _____

NO YES High fevers _____

NO YES Allergies _____

NO YES Vision difficulty _____

NO YES Hearing difficulty _____

Medical/general precautions while working with your child: _____

Adaptive Equipment Needs: hand splint, AFO, glasses, hearing aids, wheelchair, oxygen, other: _____

Recent Dental Work (including cleanings, extractions, etc.): _____

DEVELOPMENTAL HISTORY

When did your child begin the following?

Sitting without support	< 5 mos.	5-8 mos.	> 8 mos.
Crawling on hands and knees	< 6 mos.	6-9 mos.	> 9 mos.
Walking unassisted	< 10 mos.	10-18 mos.	> 18 mos.
Saying first few words	< 10 mos.	10-16 mos.	> 16 mos.
Talking in simple sentences	< 15 mos.	15-36 mos.	> 36 mos.
Staying dry during the day	< 24 mos.	24-40 mos.	> 40 mos.

Has your child received therapy in the past?

If so, please write the last date or current:

Therapy	Home	Clinic	School
Occupational			
Physical			
Speech			
Feeding			

SOCIAL/EMOTIONAL DEVELOPMENT

Child's general disposition/temperament: ___easy-going ___difficult ___slow to warm-up

Child's general activity level: ___high ___low ___average

Response to stress/frustration: ___becomes angry ___withdraws ___bites nails ___shakes ___sucks thumb

other: _____

Response when angry: ___screams ___hits ___cries ___withdraws other: _____

Response to changes in daily routine: ___adapts well ___slightly agitated ___becomes upset other: _____

What areas of development are challenging your child: _____

What are your child's strengths: _____

What does your child like to do: _____

NOTICE OF PRIVACY POLICIES

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.

Therapy Group of Tucson, PLLC is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other health care professionals within our practice for the purpose of treatment, payment, or healthcare operations.

Payment

We may disclose your health information to your insurance provider and DDD for the purpose of payment or health care operations.

Public Health

As required by law, we may disclose your health information to the public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety

We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Secure Areas

Our office and all medical records are a secured area with no public access. All staff are trained in regards to medical records security and HIPPA compliance.

Change of Ownership

In the event that Therapy Group of Tucson, PLLC is sold or merged with another organization, your health information/record will become property of the new entity.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Therapy Group of Tucson, PLLC is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon request.
- You have the right to inspect and copy your health information.
- You have the right to request that Therapy Group of Tucson, PLLC amend your protected health information. Please be advised, however, that Therapy Group of Tucson, PLLC is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Therapy Group of Tucson, PLLC.
- You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Therapy Group of Tucson, PLLC reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Therapy Group of Tucson, PLLC is required by law to comply with this Notice

Therapy Group of Tucson, PLLC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about your privacy rights, please contact Therapy Group of Tucson, PLLC by calling this office 520-232-2021. If John Kyle Meades is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights or how Therapy Group of Tucson, PLLC has handled your health information should be directed to John Kyle Meades by calling this office 520-232-2021. If John Kyle Meades is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Therapy Group of Tucson, PLLC with authorization and consent to use and disclose my protected health care information for purposes of treatment, payment, and health care operations as described in the Privacy Notice.

Signature provided on the Consent, Release, and Assignment page.

Consent, Release, & Assignment

I certify the above is a complete and accurate account of all medical insurance policies.

** I give permission to Therapy Group of Tucson, PLLC and the contracted therapists to contact my physician to discuss screening results and obtain physician's orders for therapy evaluation and treatment.

Physician: _____

Clinic Phone Number: _____

** _____ I grant permission for a photo/image that includes my child, without any other personal identifiers, to be published on the Therapy Group of Tucson, PLLC website/Facebook.

** _____ I DO NOT grant permission for a photo /image that includes my child, without any other personal identifiers, to be published on the Therapy Group of Tucson, PLLC website/Facebook.

Child's name (print) _____

I consent to Therapy Group of Tucson, PLLC providing an evaluation and/or ongoing therapy services.

I understand that evaluation results and therapy recommendations are available to me upon request. Therapies being provided are: OCCUPATIONAL EVALUATION and/or OCCUPATIONAL THERAPY

I authorize the release of information for exchange between Therapy Group of Tucson, PLLC, Division of Developmental Disabilities and physician's office as they apply to the provision of therapies.

I have received a copy of the Notice of Privacy Practices for Protected Health Information.

I authorize the release of all information in order to process claims for services. I authorize direct payment to Therapy Group of Tucson, PLLC. Payments received from the HMO or insurance company to the consumer will be forwarded to Therapy Group of Tucson, PLLC.

Patient/Guardian printed Name: _____

Patient/Guardian Signature: _____

Today's Date: _____