North Valley PEDIATRIC THERAPY

Therapy Intake Form

Thank you for your interest in our therapy services. To help better serve you, please provide us with the information requested below. Please be assured that the information you provide will be held confidential, and is necessary for our staff to determine and provide appropriate evaluation and therapy services.

Child's Information

Today's Date:_____

Child's Name:_____ Date of Birth:_____

Date of Birth:_____ Age:_____ Grade level:_____ Sex: ☐M ☐F

Diagnosis:_____ Age of diagnosis:_____

Please Specify all services you are interested in:

☐Speech Therapy ☐Occupational Therapy ☐Physical Therapy ☐Feeding Therapy

☐Sensory Integration Therapy ☐Group Sessions

Referring physician:_____ Office Number:_____

How did hear about us?:_____

Main Concerns / Reason for Referral:_____

_____

_____

_____

Please list 3 goals you would like to see your child achieve in therapy:

1._____

2._____

3._____

Please list strong motivators for your child (favorite activities, toys, movies, foods, songs, etc.:_____

_____

_____

What are your child's biggest strengths?_____

What are your child's biggest struggles? _____

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Suite A145
Phoenix, AZ 85086

www.nvpediatrictherapy.com

F: (602) 325-0482
P: (602) 808-9912

North Valley PEDIATRIC THERAPY

Parent Contact Information

Primary Parent/Guardian name: _____
Relationship to the child: _____
Address: _____
City: _____ Zip code: _____
Email address: _____
Cell Phone: _____ Home Phone: _____ Work Phone: _____
Please check which numbers we can leave a message: ☐Cell ☐Home ☐Work
Preferred Contact Method (text/email/phone): _____
Employer: _____ Occupation: _____

Parent/Guardian name: _____
Relationship to the child: _____
Address: _____
City: _____ Zip code: _____
Email address: _____
Cell Phone: _____ Home Phone: _____ Work Phone: _____
Please check which numbers we can leave a message: ☐Cell ☐Home ☐Work
Preferred Contact Method (text/email/phone): _____
Employer: _____ Occupation: _____

Emergency Contact: _____
Name: _____ Phone: _____

Does your child have a case manager? ☐Yes ☐No
If yes, please provide his/her name, agency and contact information: _____
_____

Please list who lives with the child:
Name: _____ Sex: ☐M ☐F Age: _____ Relationship: _____
Name: _____ Sex: ☐M ☐F Age: _____ Relationship: _____
Name: _____ Sex: ☐M ☐F Age: _____ Relationship: _____
Name: _____ Sex: ☐M ☐F Age: _____ Relationship: _____

Please specify living and visitation arrangements if the child is not living with both biological parents: _____
_____
Specify who has legal custody: _____
What languages are spoken in the home: _____
Please specify any cultural factors that need to be accommodated as part of your child's treatment: _____
_____

North Valley PEDIATRIC THERAPY

Medical History

Birth History: ☐Biological Child ☐Adopted ☐Foster Child
Weeks' Gestation:_____
Delivery: ☐Vaginal ☐C-section Reason for C-section:_____
Weight at birth:_____
Complications during pregnancy: ☐No ☐Yes If yes, please describe:_____

Complications at birth: ☐No ☐Yes *Please Describe:*_____

After birth, how long was your child in the hospital before discharge:_____
Any supportive care provided while in the hospital before discharge:_____
Describe any health problems or illnesses during the first 2 weeks of life:_____

Did your child pass their newborn hearing screen: ☐No ☐Yes
Has your child's hearing been formally retested since birth? ☐No ☐Yes
If yes, please indicate by whom, date and results:_____

Does your child wear glasses: ☐No ☐Yes
Has your child's vision been formally tested? ☐No ☐Yes
If yes, please indicate by whom, date and results: _____

Do you have any concerns with your child's hearing or vision? ☐No ☐Yes
If yes, please explain:_____

Pertinent Medical History (If checked, please explain and include approximate age)
☐Chronic Ear infections _____
☐Ear tubes_____ Were tubes ever recommended? ☐No ☐Yes
☐Childhood illnesses _____
☐Frequent strep throat, colds or respiratory viruses_____
☐Mental health issues_____
☐Physical disability_____
☐Head injuries_____
☐Asthma_____
☐Tonsillectomy_____
☐Adenoidectomy_____

☐ER visits_____
☐Overnight hospitalizations_____
☐Surgeries or procedures_____
☐Seizures_____
☐Allergies (food, environmental, latex, meds, etc.) Is your child anaphylactic? ☐No ☐Yes
Please list and explain:_____
☐Previous orthopedic injuries_____
☐Genetic disorder_____
☐Restrictive diet_____
☐Reflux (GERD)_____

☐Previous or current therapy services/Where/When/Duration_____
_____

*Please provide any recent evaluation and/or progress reports_____
_____
_____

Other_____
_____

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Developmental History

Please give approximate age ***in months*** when your child reached the following milestones:

Rolled both directions:_____
Able to sit alone:_____
Crawled:_____
Walked:_____
Babbled: _____
Said first word:_____
Put 2-3 words together meaningfully:_____
Toilet trained:_____
At what age, did you *first* become concerned about your child's development?_____
Does your child use any adaptive equipment or augmentative communication device? ☐No ☐Yes
If yes, please explain_____
_____

Other developmental concerns (If checked, please explain and include approximate age)

☐Difficulty latching onto breast or bottle as infant_____
☐Difficulty transitioning to solid food_____
☐Excessive drooling_____
☐Overstuffs mouth with food_____
☐Coughs, gags or chokes when eating_____
☐Gagging during feeding with only sight or smell_____
☐Avoids certain food tastes/textures_____
☐Difficulty chewing food_____
☐Picky eater _____
If yes, what will your child eat willingly?_____
If yes, what does your child refuse to eat?_____
☐Often bites, chews, licks non-edible objects_____
☐Gets upset if food gets on his/her hands_____
☐Appears to have weak arms, legs or trunk_____
☐Body appears "floppy"_____
☐Body appears "stiff"_____
☐Seems uncoordinated compared to same age peers_____
☐Clumsy (trips, falls, bumps into things)_____
☐Difficulty climbing stairs_____
☐Poor balance_____
☐Unable to catch a ball_____
☐Unable to kick a ball_____
☐Walks on toes_____

☐Sits on floor with legs in a "W"position
☐Delayed in developing motor milestones
☐Weak hands
☐Poor pencil grasp
☐Difficulty with handwriting
☐Difficulty dressing self or using feeding utensils
☐Easily distractible
☐Difficulty attending to a task until completion
☐Irrational fears
☐Extreme fear of movement when roughhousing (cries, clings to adult)
☐Fear of slides, swings and playground equipment/overly cautious
☐Little regard for safety/ takes excessive or dangerous risks
☐Always "on the go" / difficulty with seated/structured tasks
☐Seems "too rough"/ crashes into furniture, jumps off things, rough with other kids, breaks things
☐Unconsciously spins or rocks self
☐Bangs head
☐Distress with touching certain textures
☐Distress with being touched, hugged, kissed
☐Distress wearing certain clothing
☐Distress with getting hands messy/dirty
☐Distress with bath (especially having hair washed)
☐Distress with hair and teeth brushing
☐Excessively likes to touch people or objects
☐Eagar to get messy / dirty and will often wipe all over self
☐Distress with loud or unexpected noises (vacuum, blender, sirens, dogs barking, etc.)
☐Distress with loud environments (parties, kids play areas, restaurants, people talking)
☐Covers ears
☐Have extreme tantrums that last a very long time
☐Once he/she gets upset they have a very difficult time calming back down/inconsolable
☐Behavioral problems
☐Self-injurious behaviors
☐Aggression towards adults, other children or property
☐Academic problems
☐Has poor sleep habits / poor sleep routine
☐Difficulty "going with the flow" when routine changes
☐Difficulty transitioning from one activity to another / will have tantrums
☐Difficult time interacting with other children/plays mostly by himself/herself
☐Doesn't seem to understand social cues
☐Makes little eye contact
☐Difficulty engaging in purposeful play with toys and others
☐Limited pretend play
☐Fixates on TV / Tablet / Smart phone

☐Lines up toys/has difficulty playing with its intended purpose_____
☐No verbal language_____
☐Has limited vocabulary_____
☐Hard to understand your child_____
☐Echolalia (repeats common words/phrases)_____
☐Did your child ever lose words or language skills? What age?_____
☐Does your child attempt speech and then get mad when people don't understand him/her_____

Education History

Please list all current and past schools your child has attended and any services received?

School Names	Dates of attendance	Grade Completed	Services Received
_____	_____to_____	_____	_____
_____	_____to_____	_____	_____
_____	_____to_____	_____	_____
_____	_____to_____	_____	_____

Authorizations

Authorization and Consent for Treatment

I consent to and grant permission to the employees of North Valley Pediatric Therapy to render to my child routine clinical care including evaluations, educational services, and therapy activities/procedures during my receipt of services. I also acknowledge that North Valley Pediatric Therapy has not made any guarantee or warranty as to the result of any services or treatments given.

Authorization Signature:_____ Date:_____

Consent to Bill Health Insurance

North Valley Pediatric Therapy is considered in-network for most major insurance carriers and considered out-of-network for all insurance plans. If you have out-of-network benefits with your insurance plan, it may be possible to be reimbursed by your insurance company for therapy services.

North Valley Pediatric Therapy will verify benefits only upon the initial evaluation/treatment session. Verification of benefits is not a guarantee of coverage or payment and all insurance payments are subject to medical necessity and eligibility at the time services are rendered. I understand that an office visit and specific therapy charges are incurred at each appointment. Knowledge of maximum number of visits, deductible amounts and out of pocket maximums are your responsibility. Co-pays, deductibles and coinsurance are due at the time of service. It is your responsibility to update us on any changes made to your insurance.

Questions regarding insurance claims or payments should only be directed to the billing department of North Valley Pediatric Therapy and not to treating therapists.

I consent for North Valley Pediatric Therapy, including its providers to bill my private health insurance. I also consent to the release of any information necessary to file a claim with my health insurance plan.

Authorization Signature:_____ Date:_____

Will you be filing with your insurance company? ☐Yes ☐No

Primary Insurance:

Insurance name:_____ Health Plan, if Applicable:_____
Member's name (Policy holder):_____ Member's date of birth:_____
Member's relationship to child:_____
Member's Employer:_____
Member ID#:_____ Group Policy#:_____ Effective Date:_____
Insurance phone #:_____

Secondary Insurance:

Insurance name:_____ Health Plan, if Applicable:_____
Member's name (Policy holder):_____ Member's date of birth:_____
Member's relationship to child:_____
Member's Employer:_____
Member ID#:_____ Group Policy#:_____ Effective Date:_____
Insurance phone #:_____

**Please include front/back copies of all insurance cards

Email info@nvpediatrictherapy.com for questions regarding insurance and other payment options.

Credit Card Authorization

North Valley Pediatric Therapy requires that we have a credit card on file for all clients. Client authorizes North Valley Pediatric Therapy to charge any outstanding balances to the credit card number provided. We will contact you before charging a balance over $250. Client aggress that all information provided is accurate and complete.

Name on Card:_____
Patient (child) name:_____
Credit Card Type: ☐Visa ☐MC ☐AMEX ☐Discover
Credit Card Number:_____
CVC Number:_____
Expiration Date:_____
Email address for receipt:_____
Billing address:_____
State:_____Zip code:_____
Phone number:_____

Authorization Signature:_____ Date:_____

Release and Exchange of Information

*If you are using insurance to pay for services, we must have contact information and permission to exchange information with your child's primary physician prior to initiating services.
Please list all specialists involved in your child's care (all doctor's, schools, therapy services etc.)

Profession: Physician/Pediatrician
Name_____**Phone**_____**Fax**_____
Address_____

Specialist: _____
Name_____**Phone**_____**Fax**_____
Address_____

Specialist:_____
Name_____**Phone**_____**Fax**_____
Address_____

Name of child: _____Date of Birth:_____
Name of parent(s) or Guardian:_____Phone:_____

_____If you are separated or divorced, please verify you are the party above and have legal custody by initialing

I give permission for North Valley Pediatric Therapy to release and/or exchange information with the professionals whom I have identified. I authorize North Valley Pediatric Therapy to release and/or exchange information with my insurance provider(s).

Parent/Guardian Authorization Signature:_____Date:_____

Acknowledgement of Notice of Privacy Practices

I have read and understand the Notice of Privacy Practices found on www.nvpediatrictherapy.com under Getting Started.

Authorization Signature:_____ Date:_____

Checklist

*Please check that all items are completed before submitting your intake packet to ensure a faster enrollment process.

___Completed Intake Packet
___Copy front and back of all insurance cards
___Recent therapy evaluations and/or progress reports
___Signature/date for Authorization and Consent for Treatment
___Signature/date for Consent to Bill Health Insurance
___Signature/date for Credit Card Authorization
___Signature/date for Release and/or Exchange of Information
___Information of all specialists involved in your child's care
___Signature/date for Acknowledgement of Notice of Privacy Practices