Spot On Therapy Group

Spot On Therapy Group, LLC
Client Contact Information

Today's Date _____

Client Full Name: _____ DOB: _____
Social Security Number _____ Gender _____
Address: _____
City: _____ State _____ Zip _____
Email Address: _____
Home Phone: _____ Cell Phone: _____

Referred by:(name and title) _____
Primary Care Physician _____
Name of Practice _____
Address _____ Phone _____

____ By initialing here, you authorize/give permission for Spot On Therapy Group to contact you via the email address provided above, regarding appointments, and to send relevant medical information, including reports.

In case of emergency contact:

Name _____ Phone _____
Relationship to client _____

Insurance/Payment Information
Person responsible for payment of services: _____
Insurance Company _____
Primary Insured's Name _____ DOB _____
Insured's ID Number _____ Insured's Group Number _____
Relationship to client _____ Primary Insured's Social Security #_____

Do you have a secondary insurance?
Insurance Company: _____ Policy/ID# _____

If my insurance policy/plan limits the number of therapy visits allowed, I understand that I am responsible for keeping track of the number of used or remaining visits. If the client is seen beyond the approved number of visits, I understand that I am responsible for all charges that exceed the allowed number of visits approved by my insurance company.
Initials _____

Spot On Therapy Group

RELEASE OF INFORMATION AGREEMENT

Client Full Name _____ Date of Birth _____

I request and authorize Spot On Therapy Group, LLC to release/exchange healthcare information of the client listed above to:

Name _____
Phone _____ Fax _____
Business/Affiliation with Client _____
Address _____
City/State _____ Zip _____
This authorization applies to the following information (please be specific)
_____
_____
This authorization expires on _____

Name _____
Phone _____ Fax _____
Business/Affiliation with Client _____
Address _____
City/State _____ Zip _____
This authorization applies to the following information (please be specific)
_____
_____
This authorization expires on _____

Name _____
Phone _____ Fax _____
Business/Affiliation with Client _____
Address _____
City/State _____ Zip _____
This authorization applies to the following information (please be specific)
_____
_____
This authorization expires on _____

_____ _____
Print client name Date

_____
Client's signature

Spot On Therapy Group

ATTENDANCE, CANCELLATIONS, AND DISCHARGE POLICIES

Regular and consistent attendance is required in order to show treatment progress.

Cancellations must be made with at least 24 hours notice or a fee will be charged. We understand that due to illness or other unexpected events it may be necessary for you to occasionally cancel a therapy appointment. You can leave a message if you reach voicemail. We appreciate two weeks' notice of vacation plans. Make up sessions are encouraged.

MISSED OR NO SHOW APPOINTMENTS: A fee of $50.00 will be assessed if the 24-hour notice is not given; this fee is charged in an effort to deter unnecessary missed appointments. This missed appointment fee will be due and payable prior to your next scheduled treatment session. This fee cannot be billed to your insurance company. Two consecutive no show/no call appointments may result in your removal from the therapy schedule.

TARDINESS: We have reserved a specific amount of time for your appointment because we feel that you need that amount of therapy time every week in order to make progress. If you are tardy for your appointment, then you will be seen for the remaining amount of time left in your session and will conclude at the end of the regularly scheduled time. We reserve the right to remove you from the schedule if you do not come to therapy at your scheduled time on a consistent basis. **Being absent or tardy for too many appointments will impede the therapy process and result in the inability to show progress. Insurance companies may refuse payment if progress cannot be shown due to lack of attendance. ** If you are faced with a scheduling challenge, please see the front desk in order to find a more preferable therapy time.

DISCHARGE POLICY It is the policy of Spot On Therapy Group to discharge clients who meet one of the following criteria: no longer demonstrates need for intervention, does not appear to benefit from continued services, is not meeting financial responsibilities to Spot On Therapy Group, does not meet the required attendance, is requested by the client, or at the discretion of the agency.

By signing below, I acknowledge that I have fully read and understand the Spot On Therapy Group Attendance, Cancellations, and Discharge Policy.

Client Printed Name _____ Date _____

Client Signature _____

Spot On Therapy Group

FINANCIAL POLICY AGREEMENT

If you have Health Insurance, we want you to receive your full benefit. Our office team can assist you in completing your insurance forms and verifying benefits/coverage. If Spot On Therapy Group is in network with your insurance provider, you are responsible for your deductible and the co-payment (the portion insurance does not cover) at the time services are provided. Please note, the portion of the total fees covered by your insurance may be different than the amount quoted on the day of service. You are encouraged to verify your insurance policy benefits. You are responsible for any outstanding balance after insurance has been applied.

By initialling, I understand that I am responsible for the payment of a one-time $100 educational reporting fee for each initial evaluation. This fee will not be submitted to insurance and is the client's responsibility. Initial _____

PAYMENT FOR SERVICES: Spot On Therapy Group accepts cash, checks, Visa, MasterCard, Discover, American Express and PayPal.

CONTRACTUAL AGREEMENT:

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY AND SIGN BELOW

I understand all client co-payments are due payable at the time services are rendered. I authorize payment directly to Spot On Therapy Group for the benefit otherwise payable to me under the terms of any insurance. I understand I am financially responsible for all charges arising from the treatment of the below named client and any insurance payments will be credited to the account. In the event the bank returns any check given in payment on this account, unpaid for any reason, a $30.00 charge will be added to the account balance each time a check is returned. If all charges are not paid in full within sixty (60) days from the date of service, I agree to pay the service charge of eighteen percent (18%) per month, twenty-one percent (21%) annual interest on the unpaid balance, along with a $5.00 late charge. If this account is referred to an attorney for collection, I agree to pay all costs of collection, including, but not limited to attorney's fees and all court costs.

By signing below, I acknowledge that I have fully read and understand the Spot On Therapy Group Financial Policy Agreement.

Client Full Name: _____

Client Signature _____ Date _____

Spot On Therapy Group

PRIVACY PRACTICES POLICY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinicians or other treatment team members. *We may disclose PHI to any other consultant only with your specific written authorization.*

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support certain business activities including, but not limited to, sharing your PHI with third parties that perform various business activities (e.g., billing or typing services) only if we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization. Your PHI may be disclosed via email, if you have given written permission, for appointment reminders, and to provide information about treatment alternatives or other health-related benefits and services.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use or disclose information to family members that are directly involved in you or your child's treatment *with your verbal permission.*

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI that we maintain about you. To exercise any of these rights, please submit your request in writing:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask for amendment of the information, although we are not required to agree to the amendment.

- **Right to an Accounting of Disclosures.** You have the right to request an accounting of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice. **Please notify Spot On Therapy Group, LLC if you would like a copy. Please also check the appropriate box on the signature page, indicating you received a copy of this notice.

Spot On Therapy Group

Spot On Therapy Group, LLC
Written Acknowledgement Form

By signing this form, I acknowledge and agree as follows:

I have been given the opportunity to read Spot On Therapy Group's Notice of Privacy Practices policy statement prior to signing this acknowledgement form.

The Privacy Practices policy statement includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for Spot On Therapy Group, LLC to treat me and/or my child and to obtain payment for that treatment.

_____ By initialing, I indicate that I ***would*** like a printed copy of Spot On Therapy Group's Notice of Privacy Practices Policy.

_____ _____

Printed Name Date

_____

Signature

Spot On Therapy Group

Spot On Therapy Group
Adult Client Background Information

Full Name: _____ Age: _____Date: _____

DOB: _____ Occupation: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____

Email: _____

How did you find out about us? _____

What is your major concern that led you to seek help?

_____

_____

How long have you had these concerns? _____

Is there a particular reason you are seeking an appointment at this time?_____

Please check the areas of your life that are affected by these issues/concerns:

_____home _____school _____work
_____Church _____public places (i.e., stores) please specify_____
_____other _____

With whom do you currently live with? _____

_____

What other concerns do you have?

_____

_____

_____

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Are you currently being seen by other professionals? Please check any of the following whom you have contacted and/or from whom you have received services and include any formal diagnoses given.

Area of Service	Clinician	Date	Diagnosis/Recommendations
___ Occupational Therapists	_____	_____	_____
___ Physical Therapist	_____	_____	_____
___ Speech Language Pathologist	_____	_____	_____
___ Vision Specialist	_____	_____	_____
___ Hearing Specialist	_____	_____	_____
___ Neurologist	_____	_____	_____
___ Orthopedist	_____	_____	_____
___ Psychologist	_____	_____	_____
___ Counselor	_____	_____	_____
___ Other:	_____	_____	_____

Are you allergic to any medications? No _____ Yes _____ If yes, list allergy and reaction:
_____

Are you allergic to anything other than medications? No _____ Yes _____ If yes, list allergy and reaction:
_____

1. List any medications you are currently taking in the columns below. (Use back of sheet if needed)

Medication(s)			
Dose			
Purpose			
Date Started			
Physician			
Side Effects			

What medical or physical problems do you have or have you had? Mark an *X* and then describe below.

	Past	**Present**	**If yes, please explain**
Cardiac Problems			
Allergies or food sensitivities			
Ear infections, frequent colds			
Poisoning or drug use or overdose			
Hospitalizations or surgeries			
Vision/hearing difficulties			

	Past	Present	If yes, please explain
Muscle or Verbal Tics			
Speech disorders			
Serious accidents/Injuries			
Any blows to the head or concussions			
Any loss of consciousness or seizures			
Very sensitive to feel of labels, seams, textures in clothes			
Bothered by loud or unexpected noises			
Very picky eater			
Shortness of breath			
Headaches			
Dizziness			
Motion Sickness			
Unusual Fears/Worries			
Depression			
Anxiety			
Smoke			
Drink			
Sleep Problems			

Please circle any of the following sleep problems you experience and then describe the severity or frequency in the space below:

Delays going to bed
Difficulty falling asleep
Difficulty waking in morning
Physically restless sleep
Not rested after sleep

Nightmares (bad dreams)
Sleeping too much
Frequent waking
Teeth grinding
Snoring

Bedwetting
Sleep Apnea

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Other:

_____

_____

_____

_____

	Yes	No	If yes, please explain
Pregnancy problems			
Difficulties during birth			
1st year of life problems (colicky, hard to soothe, problems nursing, etc)			
Nursing, weaning, sleeping problems			
Motor development delays			
Speech & Language delays			
Toilet training delays			
Social Problems			
Attention or learning problems			
Depression, anxiety, mental illness			
Personal family substance abuse			
Physical, sexual, emotional abuse			
Marital problems, separations & divorce			
Trauma and significant stressors			

What is the furthest grade reached or highest degree attained in school? _____

What was the Grade Point Average in your last schooling? _____

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Please mark with an "X" when any of the following has occurred.

	Elementary School	Middle School	High School	College	Work
Learning/academic problems	_____	_____	_____	_____	_____
Daydreaming	_____	_____	_____	_____	_____
Hyperactivity	_____	_____	_____	_____	_____
Impulsivity	_____	_____	_____	_____	_____
Reading difficulties	_____	_____	_____	_____	_____
Math difficulties	_____	_____	_____	_____	_____
Writing difficulties	_____	_____	_____	_____	_____
Poor grades	_____	_____	_____	_____	_____
Homework problems	_____	_____	_____	_____	_____
Behavior problems at school	_____	_____	_____	_____	_____
Anger	_____	_____	_____	_____	_____
Oppositional	_____	_____	_____	_____	_____
Destructive	_____	_____	_____	_____	_____
Peer problems	_____	_____	_____	_____	_____
Strongly disliked school	_____	_____	_____	_____	_____
Resource or other remedial assistance	_____	_____	_____	_____	_____
Special Education placement	_____	_____	_____	_____	_____
Individualized Education Plan (IEP)	_____	_____	_____	_____	_____
Other (Please explain on back of page)	_____	_____	_____	_____	_____

_____

_____

Please check any of the following that are <u>current</u> problems

____Difficulty learning to read, blending sounds or reading smoothly
____Problems tracking while reading (losing place, missing words)
____Difficulty remembering what was read
____Difficulty with math calculations
____Difficulty understanding math concepts
____Difficulty at written composition
____Difficulty spelling
____Poor handwriting (even if writing slowly)
____Difficulty drawing or copying figures
____Poor sense of direction
____Poor balance or coordination, clumsy

What other sources of personal strength do you call upon to face problems?(i.e., exercise, friends, music, faith, etc.)

_____

_____

_____

Spot On Therapy Group

Please describe your greatest strengths and any special abilities or talents.

_____
_____
_____

How healthy is your diet? What problems, if any, have you had with sugar cravings, dieting or maintaining weight?

_____
_____
_____

How much caffeine do you consume daily? _____ In what form? (coffee, soda, energy drink)_____
How does caffeine affect you?

_____

Do you exercise? _____Yes _____No
If yes, what form of exercise and how often

_____
_____
_____

Please list hobbies, special interests

_____
_____
_____

Please include anything else you think might be helpful for us to know about you.

_____
_____
_____
_____

Thank you for completing this form!