Patient Name: _____

NEW PATIENT INTAKE

Patient Information

Patient's Legal Name:			
	First	*MI*	*Last*

DOB:	/ /	*Age:*		☐ *M*	☐ *F*	*Home Phone:*		*Cell Phone:*	

Home Address:				
City/State/Zip Code:				
E-mail Addresses:				
How may we contact you?	☐ *Call*	☐ *Text*	☐ *E-mail*	☐ *Other:*

Parent/Guardian Information

Parent/Guardian Legal Name:			
	First	*MI*	*Last*

DOB:	/ /	*Age:*		☐ *M*	☐ *F*	*Home Phone:*		*Cell Phone:*	

Home Address:				
City/State/Zip Code:				
E-mail Addresses:				
How may we contact you?	☐ *Call*	☐ *Text*	☐ *E-mail*	☐ *Other:*

Patient Emergency Contact Information: *Please list who we may call in case of an emergency:*

Name:		*Home Phone:*		*Cell Phone:*		*Relationship:*	
Name:		*Home Phone:*		*Cell Phone:*		*Relationship:*	

Patient's Physicians: *Please list all of your child or loved one's physicians, practice name, specialty, and phone number*

Name:		*Practice Name:*		*Specialty:*		*Office Phone:*	
Name:		*Practice Name:*		*Specialty:*		*Office Phone:*	

Patient Treatment and Health History:

For which therapy service(s) have you come to Carolina Therapeutics, PLLC?			
☐ *Speech Therapy*	☐ *Physical Therapy*	☐ *Occupational Therapy*	☐ *ABA Therapy*
At what locations do you authorize clinicians to perform therapy services?			
☐ *Home*	☐ *Daycare*	☐ *Other*	
If you authorize clinicians to perform therapy services at your child's daycare, please provide the daycare name and address			
Daycare Name:		*Daycare Address:*	
If you authorize clinicians to perform therapy services outside of the home, please provide the name and address of the location			
Location Name:		*Location Address:*	

Carolina Therapeutics, PLLC

Patient Name: _____

What are your primary reasons for seeking therapy services at this time?			
Is your child or loved one verbal or nonverbal?			
☐ *Verbal* ☐ *Nonverbal*			
Has your child or loved one ever received Speech Therapy, Physical Therapy, or Occupational Therapy in the Past?			
☐ *Yes* ☐ *No*			
If Yes, please write the name and therapy practice of your child's prior Speech, Physical, and/or Occupational Therapists			
Name:		*Therapy Practice Name:*	
Name:		*Therapy Practice Name:*	
Name:		*Therapy Practice Name:*	
Has your child or loved one ever been diagnosed with Autism?			
☐ *Yes* ☐ *No*			
If Yes, please write the name and practice of the physician or other healthcare provider that provided an autism diagnosis			
Name:		*Practice Name:*	
Name:		*Practice Name:*	
Has your child or loved one ever received ABA Therapy in the past?			
☐ *Yes* ☐ *No*			
If Yes, please write the name and therapy practice of your child or loved one's prior ABA Therapists			
Name:		*Therapy Practice Name:*	
Name:		*Therapy Practice Name:*	
If your child or loved one previously received ABA Therapy services, how many hours per week were ABA services rendered?			
Prior ABA Therapy Hours Per Week:			
Does your child or loved one currently receive therapy services of any kind through any other therapy practice?			
☐ *Yes* ☐ *No*			
If Yes, please write the name of any of your child or loved one's current therapists and the name of their therapy practice			
Name:		*Therapy Practice Name:*	
Name:		*Therapy Practice Name:*	
Please list any medical diagnoses that your child or loved one has been given:			
Please list all of your child or loved one's prescribed medications:			
Has your child or loved one been hospitalized? If so, please list the dates of recent hospitalizations:			
Does your child or loved one have any allergies of any kind? If so, please list all known allergies:			

Carolina Therapeutics, PLLC

Patient Name: _____

Patient Screening and Immunization History:

Hearing screening:	☐ *Yes*	☐ *No*	*Date:*		*Results:*	
Vision screening:	☐ *Yes*	☐ *No*	*Date:*		*Results:*	
Immunizations:	☐ *Yes*	☐ *No*	*Date:*		*Results:*	

Patient Developmental History: *Please list developmental history (for pediatric patients only)***:**

Rolling		*Finger-fed self*	
Sitting without support		*Toilet trained*	
Crawling		*Dresses self*	
First steps		*Eats with utensils*	
Babbled		*Walks without support*	
Spoke first word		*Puts several words together*	

Patient Daily Behavior: *Please indicate the patient's current level of functioning within these daily living routines*

Mealtime routines	☐ *No concerns/well*	☐ *Concerns*	☐ *Needs Assistance*
Eating/Swallowing foods/liquids	☐ *No concerns/well*	☐ *Concerns*	☐ *Needs Assistance*
Sleep/Nap schedules	☐ *No concerns/well*	☐ *Concerns*	☐ *Needs Assistance*
Engages with others	☐ *No concerns/well*	☐ *Concerns*	☐ *Needs Assistance*
Communicates with you	☐ *No concerns/well*	☐ *Concerns*	☐ *Needs Assistance*
Asks for help	☐ *No concerns/well*	☐ *Concerns*	☐ *Needs Assistance*
Plays appropriately	☐ *No concerns/well*	☐ *Concerns*	☐ *Needs Assistance*
Uses appropriate safety awareness	☐ *No concerns/well*	☐ *Concerns*	☐ *Needs Assistance*

Aggressive Behaviors	☐ *None*	☐ *Mild*	☐ *Intermediate*	☐ *Severe*
If you checked mild, intermediate, or severe, please write any known aggressive behaviors:				

Please write anything else that you would like for us to be aware of regarding the named patient:

I have read and understood the above questions, I have provided truthful responses, and I agree to the terms stated.			
Patient/Caregiver Signature:		Date:	
*** By electronically signing or typing my name on this agreement, I agree that my electronic signature is the legal equivalent of my manual signature. ***			
Printed Patient/Caregiver Name:			

Professional Therapy Services Brought to Your Doorstep!
www.carolinatherapeutics.com • info@carolinatherapeutics.com
P.O. Box 38118, Charlotte, NC 28278-8932 • Tel 704.654.8599 • Fax 980.938.6088

Patient Name: _____

HEALTH INSURANCE INFORMATION

Patient's Legal Name:			
	First	MI	Last

DOB:	/ /	Age:		☐ M	☐ F	Home Phone:	

Primary Insurance Information: *Please provide a copy of all insurance cards*

Insured's Name: (who has the policy)	First MI Last	Insured's DOB:	
Insurance Company Name		Insurance Phone #:	
Member ID #:		Group #:	

Secondary Insurance Information:

Insured's Name: (who has the policy)	First MI Last	Insured's DOB:	
Insurance Company Name		Insurance Phone #:	
Member ID #:		Group #:	

Do you have any additional insurance or other funding sources for therapy services? ☐ Yes ☐ No

If Yes, please provide all identifying information below:

FINANCIAL AUTHORIZATION & RESPONSIBILITY

I hereby authorize Carolina Therapeutics, PLLC, billing department to bill my insurance company for direct reimbursement of therapy services rendered to the named patient. Unless otherwise noted, benefit payments will be assigned directly to Carolina Therapeutics, PLLC. All copays and payments are due at the time of service. I understand that the named patient or patient's family is responsible to pay all fees accrued for services rendered, regardless of insurance verification or anticipated insurance coverage, if insurance company refuses to pay provider a portion of the fees or in full. I agree to pay all fees within 30 days after bill has been mailed, and understand that any fees not paid within 30 days will result in a late fee. In the event of a returned or invalid payment, as well as an unpaid balance over 90 days, I agree to pay any and all additional associated banking, legal and/or collection fees I understand that I am advised to fully know and understand my insurance benefits prior to my child receiving therapy services. I understand that all insurance plans are different and it is impossible for Carolina Therapeutics, PLLC, to know the specifics of my plan and/or if my plan will reimburse for services received. I agree to notify Carolina Therapeutics, PLLC, if my insurance coverage changes. I understand that I am ultimately responsible for payment of all services received.	Initials _____
I am aware that not all fees are billable to insurance companies such as materials, books, equipment, school conferences, and therapist consultations and will be billed directly to the responsible party or guardian. I understand that I am responsible for payment of these services not billable to my insurance company.	Initials _____

I have read and understand the policies stated above, I and agree to the terms as stated.

Patient/Caregiver Signature:		Date:	

*** By electronically signing or typing my name on this agreement, I agree that my electronic signature is the legal equivalent of my manual signature. ***

Printed Patient/Caregiver Name:	

Patient Name: _____

CONSENT TO TREAT

I,_____(patient/parent/guardian), knowing that _____(patient) has a diagnosis requiring therapeutic treatment, hereby voluntarily consents to such care for the aforementioned patient by Carolina Therapeutics, PLLC, as may be beneficial in the professional judgment of the patient's therapist(s) and primary care physician. I am aware that no guarantee has been made as to the effect of therapeutic intervention treatment with the named patient.	Initials _____
I am aware that gross motor activities are often encouraged during therapy and that swinging, running, climbing, jumping and other gross motor activities can be used to assist with a variety of skills and performance components the therapist may need to address. I consent to the use of gross motor activities and exempt my loved one, therapist(s), clinician(s), and owner(s) of Carolina Therapeutics, PLLC, from any injury resulting from this type of play.	Initials _____
I am aware that other persons not listed on the patient's prescription may be in the same therapy room during treatment, especially if therapy is provided in-home, at a daycare/preschool setting, or within the community setting. Carolina Therapeutics, PLLC, its clinicians, or owners, are not responsible for any accident or injury that occurs during treatment.	Initials _____
The named patient has my permission to participate in a natural environment setting during therapy sessions. I understand that this presumes the presence of a wide variety of other people including but not limited to, other children, siblings, parents, professionals, volunteers, or students. The named patient may participate in therapy in the home, school, and community as discussed by the clinician, patient, and persons involved in the treatment plan in order to maximize carryover of functional skills.	Initials _____
Each therapist will assign various activities for patients to participate in to maximize the carryover of functional skills as part of the patient's Home Exercise Plan (HEP). I have been notified that compliance with the HEP is necessary in continuing therapy services, and my insurance and other medical professionals may be notified of my participation, or lack thereof, with the HEP.	Initials _____
I agree that any and all legal claims made against Carolina Therapeutics, PLLC, its therapists, and its affiliated companies, are to be decided by binding arbitration pursuant to the rules of the American Arbitration Association utilizing the laws of the State of North Carolina. I agree to pay all costs associated with binding arbitration, in addition to the attorney's fees of Carolina Therapeutics, PLLC, in the event my legal claims are unsuccessful.	Initials _____

PHOTOGRAPHY & VIDEOS

I, _____, authorize Carolina Therapeutics, PLLC, to take photographs/video to be used for the following purposes:

☐ Track therapy progress ☐ Display in clinic ☐ Display for commercial use (website, brochures, flyers, etc.)

I have read and understand the policies stated above, I and agree to the terms as stated.			
Patient/Caregiver Signature:		Date:	
**** By electronically signing or typing my name on this agreement, I agree that my electronic signature is the legal equivalent of my manual signature. ****			
Printed Patient/Caregiver Name:			

Patient Name: _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

(HIPAA Release)

Patient's Legal Name:			
	First	MI	Last

DOB:	/ /	Patient Record #		SS#	

I, _____ do hereby authorize

(Patient, Legal Guardian, or Spouse)

_____ to disclose information from the

(Name of Provider/Plan/Agency)

records or billing of the above-named patient to: Carolina Therapeutics, PLLC, PO Box 38118, Charlotte, North Carolina, 28278, phone: 704-654-8599, fax: 980-938-6088.

For the specific purpose(s) of: Any purpose deemed appropriate by my treating clinician(s) at Carolina Therapeutics, PLLC, including but not limited to treating or diagnosing any disease or condition, whether mental or physical.

Specific information to be disclosed: Any and all information which may be requested by my clinicians at Carolina Therapeutics, PLLC, me, my parent, legal guardian, spouse, attorney, or personal representative, including but not limited to, my educational records, enrollment forms, intake documents, disciplinary documents, evaluations, IEP notes, incident reports, medical/health records or insurance claim materials in your possession, custody, and control, and if necessary, to allow all persons or entities stated herein or anyone appointed by them, to examine these records, or any records containing medical records, medical notes, or medical bills which you may possess regarding my education, physical or mental health conditions, healthcare, or treatment.

I understand that this authorization will expire on the following date, event or condition: when either I, my parent, legal guardian, or spouse revokes this authorization in writing.

I understand that if I fail to specify an expiration date or condition, this authorization is valid indefinitely. I also understand that I may revoke this authorization at any time. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I have read and understand the policies stated above, I and agree to the terms as stated.			
Patient/Caregiver Signature:		Date:	
*** By electronically signing or typing my name on this agreement, I agree that my electronic signature is the legal equivalent of my manual signature. ***			
Printed Patient/Caregiver Name:			

Patient Name: _____

ATTENDANCE POLICY

Consistent therapy attendance is required by Carolina Therapeutics, PLLC, and it is critical for your child or loved one's success. Nevertheless, we realize that both children and adults suffer sudden illnesses and that emergencies occur. With this in mind, our attendance policy allows for two (2) missed visits (without 24 hours notice) to accommodate those situations. Early notification of a cancellation allows us to provide therapy services to other patients waiting to be seen for therapy. It also provides us with a better opportunity to reschedule your loved one to another time during the week to make up for the missed visit. It is expected that cancelled visits be rescheduled in order to comply with your loved one's plan of care and physician's order.

In order to allow us to meet the needs of all the patients we see, we have attendance policies that, if violated, require that the treating therapist remove your child from a permanent spot on their caseload and discharge the patient from further therapy services. These policies are as follows:

- **Cancellation of three (3) appointments with less than twenty-four (24) hours notice in a ninety (90) day period for any reason;**
- **Not showing or being ready for your scheduled appointment time for two (2) appointments in a ninety (90) day period without prior contact to Carolina Therapeutics, PLLC; or,**
- **Cancellation of three (3) appointments for any reason that are not rescheduled (regardless of advance notice) in a ninety (90) day period.**

Please call the office and/or the treating clinician as soon as you realize that your loved one will not be able to attend therapy. You may leave a message on our office voicemail twenty-four (24) hours a day.

PARENT/GUARDIAN PRESENCE

Carolina Therapeutics, PLLC, values the importance of establishing and maintaining therapeutic programs for all of the patients for which we provide therapy services. Parent/guardian involvement is key to your loved one's success from therapy services. Demonstration of your participation within your loved one's individualized home-exercise plan is critical for continual progress towards functional outcomes, and your insurance coverage may require documentation of your compliance. Please be aware that non-compliance with the discussed home-exercise plan may limit your loved one's ability to receive services.

I have read and understand the policies stated above, I and agree to the terms as stated.			
Patient/Caregiver Signature:		Date:	
*** By electronically signing or typing my name on this agreement, I agree that my electronic signature is the legal equivalent of my manual signature. ***			
Printed Patient/Caregiver Name:			

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