New Patient Intake Paperwork

☐ Braselton Clinic ☐ Toccoa Clinic

Child's Name				Today's Date			
Date of Birth		Gender		☐Male ☐Female			
Address		City		State		Zip	
Parent/Guardian 1		DOB		Relationship			
Phone		Email					
Employer		Position					
Parent/Guardian 2		DOB		Relationship			
Phone		Email					
Employer		Position					
Who does child live with? (check all that apply)	☐Mother ☐Father ☐Grandparent ☐Other:						
Are parents/guardians:	☐Married ☐Divorced ☐Separated ☐Other:						
Sibling Name		Age					
Sibling Name		Age					
Sibling Name		Age					
Referred to Aspire for-	☐ Occupational Therapy	☐ Speech Therapy	☐ Physical Therapy				
Child's Diagnosis (if known)-							
Referring Physician		Practice & Location					
Other Physician/ Specialist		Practice & Location					
Other Physician/ Specialist		Practice & Location					
Primary Insurance Company							
ID #		Group #					
Subscriber Name		Social Security #					
Secondary Insurance Company							
ID #		Group #					

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Describe in your own words the nature of your concerns about your child's development-	
Has your child received any previous therapy for this concern?	☐ Yes ☐No
If YES, what type?	☐Occupational Therapy ☐Speech Therapy ☐Physical Therapy ☐Other:

Medical History

Mother's Health During Pregnancy- ☐UNKNOWN

Any infections/illnesses during pregnancy?	☐YES ☐NO
Any shocks or unusual stress during pregnancy?	☐YES ☐NO
Did water break more than 24 hours before delivery?	☐YES ☐NO
Developed toxemia/high blood pressure?	☐YES ☐NO
Any complications during delivery and/or labor?	☐YES ☐NO
If YES, please explain	

Child's Health at Birth-

Was child premature?	☐YES ☐NO	How many weeks early?	
What was the child's birth weight?			
Check all that apply			
☐Cesarean section	☐Small for age		
☐Breech presentation at delivery	☐Heart defect		
☐Cord wrapped around neck	☐Required transfusion		
☐Forceps required	☐Seizures		
☐Birth injuries	☐Infection at birth		
☐Insufficient oxygen	☐Feeding problems as newborn		
☐Did not cry right away	☐Needed Respirator	How long?	
☐Respiratory problems	☐Jaundiced	How long under lights?	
☐Required hospitalization	How long?		

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Current Medications-

Name	Dosage	Frequency	Reason

Surgeries/Medical Procedures: (please list all)

Procedure	Date

		If YES, please explain-
Any known allergies?	☐Yes ☐No	
Any diet restrictions?	☐Yes ☐No	

Does your child have a history of recurrent ear infections?			☐Yes ☐No	
Has he/she had PE tubes placed to treat the condition?		☐Yes ☐No	Date?	
Last hearing screening?		☐Pass ☐Fail	Location?	
Last vision screening?		☐Pass ☐Fail	Location?	

Educational Information

Is your child currently enrolled in school?	☐Yes ☐ No
School name & days attended?	
What grade/classroom level?	
Does your child receive therapy at school?	☐Yes ☐ No
If yes, what type of services?	
Does your child have an IEP or 504?	☐Yes ☐ No

Developmental History

Developmental Skill	Age child completed skill independently
Began babbling?	
What was his/her first word spoken?	
Used two-word phrases?	
Fed self with fingers?	
Fed self with spoon?	
Fed self with fork?	
Drank from an open cup?	
Roll over?	
Sat without assistance?	
Crawled?	
Walked?	
Jumped with two feet?	
Toilet trained?	
Rode a tricycle?	
Rode a bicycle?	

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The following questions are posed to create a more complete picture of your child from an early infancy to present developmental stage. Please check: Yes or No

Does child?	YES	NO
Seem excessively ticklish?		
Pinch, bite or otherwise hurt self?		
Bang head on purpose?		
Attempt to injure others?		
Often seem unaware of cuts, bruises, etc.?		
Dislike the feeling of certain clothing?		
Mouth objects or clothes excessively?		
Get carsick easily?		
Walk on toes (not whole foot?)		
Lose balance easily?		
Make reversals when writing, copying, and/or reading?		
Chew on non-food items?		
Have feeding problems?		
Manipulate fasteners, buttons, zippers, or snaps?		
Take off simple articles of clothing?		
Put on clothes?		
Take off socks and shoes?		
Tie shoelaces?		
Put on socks and shoes?		
Have difficulty going to sleep?		
Wake frequently from sleep?		

You may be asked to complete a more detailed Sensory Profile at the time of the initial evaluation. If there is any additional information you would like for us to have in reference to the questions above, please share it here.

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What are your child's favorite toys and/or activities?

What typically calms/soothes your child?

Does your child become easily frustrated with activities? If yes, please describe his/her behavior.

Does your child interact with other children, or primarily play alone?

Is your child currently enrolled in any community activities (such as music class, play groups, Mother's Morning Out Program, or any sports?) If so, how would you describe your child's behavior compared to other children involved in the activities?

How did you hear about Aspire?

☐Internet		
☐Babies Can't Wait Program		
☐Pediatrician	Name	
☐Developmental Pediatrician	Name	
☐Referral from other?	Name	

Printed name of person completing this form	Relationship to child	Date

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Aspire Pediatric Therapy of Georgia Agreements

Authorization to Photograph

I give permission for Aspire Pediatric Therapy of Georgia, LLC to photograph my child for records purposes only. Aspire will not publish, copy or print the photograph for any reason without my written consent.

Consent for Treatment

I consent for Aspire Pediatric Therapy of Georgia to provide my child with Occupational, Speech, and/or Physical Therapy services. I consent to care and treatment falling under the practice guidelines of the American Occupational Therapy Association (AOTA), American Speech-Language-Hearing Association (ASHA), and the State of Georgia. I acknowledge that there is always a risk of injury with any therapy involving physical activities.

Attendance Policy

In the event that you need to cancel your appointment, please notify the clinic within 24 hours. No email cancelations will be accepted. There will be a $25 late cancelation fee for appointments canceled less than 24 hours before the appointment. There will be a $50 "no-show" fee for missing an appointment without prior notification. We understand that illness and other emergencies can happen, and we will handle those situations on a case-by-case basis.

Sickness Policy

Please be respectful and cancel your appointment in a timely manner if your child is sick. Be sure your child is symptom free for 24 hours before returning to therapy. If your child or anyone in direct contact with your child has been exposed to COVID-19, please let us know as soon as possible. We will need to cancel all appointments your child has for the next 14 days unless your child has tested negative.

Notice of Privacy Practices

If you would like to receive a copy of Aspire Pediatric Therapy of GA's Privacy Practices, please contact the front office and we can provide you with your own copy. We will also have a copy posted on our website at www.aspiretherapy.org and in the front office.

Parent/Guardian Signature	Date
Parent/Guardian Printed Name	Relationship to Patient

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Financial Responsibility Agreement

We DO NOT bill commercial insurance for initial evaluations. Initial evaluations are self-pay only for all commercially insured and uninsured patients.

I authorize Aspire Pediatric Therapy of GA, LLC to bill my insurance company for direct reimbursement of therapy services rendered to my child/dependent. We will file your insurance and submit any required supporting documentation for every visit (excluding the initial evaluation for commercially insured patients). Aspire cannot be responsible for monitoring benefits, as it is up to the patient. If my insurance payment is not received within 60 days from the date of service, my balance will be transferred to my account. At that time Aspire will provide me the necessary paperwork upon request to receive payment directly. I agree to pay the unpaid balance within 15 days after the receipt of invoice from Aspire. Furthermore, I understand that any aging accounts of 90+ days are subject to collections. Aspire Pediatric Therapy of GA. LLC will not be able to continue rendering services for my child/dependent until the balance is paid, or arrangement for payment is made, and a new financial agreement reflecting the arrangement is signed.

Beginning each plan year, patients with deductibles (excluding those with Medicaid or the Katie Beckett/Deeming Waiver) will be required to pay the patient's responsibility cost of each therapy session on the day that services are rendered until the deductible has been met. Your insurance company will be able to tell you the amount you are responsible for.

If prior approval is required by your insurance company, services will not be provided until approval has been obtained. Please be advised that prior approval is never a guarantee of payment.

Please be aware that some of and perhaps all of the services provided may be deemed "non-covered" by your insurance company. In the event your insurance denies your coverage ***you will be responsible for payment of all charges.***

All accounts with NSF/returned checks will be charged $35 per check applied.

In the event that your account has to be turned over to a collection agency, a collection fee of $36 will be applied to your account, as well as attorney fees, court fees, etc.

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Good Faith Estimate

Effective 1/1/2022

Patients Name :_____ DOB:_____

Initial Evaluations	Cost per Evaluation
Occupational Therapy	$150.00 for 1 hour
Speech Therapy	$150.00 for 1 hour
Physical Therapy	$150.00 for 1 hour
Interactive Metronome	$60.00 for 1 hour

Regular Therapy Sessions	Total Cost per Visit	
Occupational Therapy	$125.00 for 1 hour	
Speech Therapy	$75.00 for 30 minutes	
Physical Therapy	$75 for 30 minutes	$125 for 1 hour
Interactive Metronome	$30.00 for 30 minutes	

Under national law, you have the right to receive a Good Faith Estimate for the total expected cost of any medical items or services. This estimate will include any testing, equipment, or procedures provided prior to scheduling services. If you receive an invoice for more than $400 of the quote in this estimate, you have a right to file a dispute.

I understand that I am financially responsible to the organization for any charges after services are provided. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services received by the provider.

By signing this document, I acknowledge that I am aware that this is an estimate of services to be provided and not a final invoice of services.

THIS DOES NOT APPLY TO PATIENTS WITH THE FOLLOWING INSURANCES: Medicaid, Amerigroup, Peach State, or CareSource.

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Medical Records Release Form

Name of Patient: _____ DOB: _____

Patient information is needed for: Continuing Medical Care

INFORMATION TO BE RELEASED OR ACCESSED:

- ☐ All Records
- ☐ Individualized Education Plan (IEP)
- ☐ 504 Plan
- ☐ History & Physical Consultation
- ☐ Evaluation Reports
- ☐ Other : _____
- ☐ Care Plans w/ MD Signature
- ☐ ENT Report/ Hearing Screening
- ☐ Discharge Summary
- ☐ Treatment Notes
- ☐ Lab, Path, or Image Reports

Requesting Records From: _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above-named patient.

Parent/Guardian Signature	Date
Parent/Guardian Printed Name	Relationship to Patient

We appreciate your effort to help Aspire give the best possible care to this patient. Let us know if you have any questions!

Please FAX records to 678-866-6076 OR EMAIL them to mail@AspireTherapy.org

Restricted Release of Information

The following people and/or organizations DO NOT have my permission to obtain information regarding the care being rendered by Aspire:

1.	
Name of Person/Organization	Relationship/Affiliation
2.	
Name of Person/Organization	Relationship/Affiliation
3.	
Name of Person/Organization	Relationship/Affiliation

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