(P) 406-690-6996 (F) 406-206-5262

Patient Information

Last Name	First	MI	Gender	Date of Birth	
Street Address		City		State	Zip
SS #	Age:				

Parent/Gardian Info

Last	First	MI	Relationship to patient		
Street Address- *Write "same" if same above*		City		State	Zip
Phone Number	Email Address	Occupation			

Insured's Information

Last Name	First	MI	Gender		
Street Address-Write "same" if same above		City		State	Zip
Date of Birth	Relationship to Patient	Employer			
Insurance Plan Name	Participant/Member ID #	Group/Policy #			

Insurance Card must be prestented for copying at first appointment

Referring Physician/Pediatrician

Name	Clinic/Hospital name	
Primary Care Physician *if different from above*	Clinic/Hospital name	

I declare the above information is true and correct

Patient Name _____ Date _____

Signature(parent or guardian if patient is under 18 yr old) _____ Date _____

ADVANCED
THERAPY CLINIC LLC

(P) 406-690-6996 (F) 406-206-5262 Info@advancedtherapyclinic.com

ACKNOWLEDGEMENT OF RISK

In consideration of the services of Advanced Therapy Clinic llc. their officers, agents, employees, and stockholders, and all other persons or entities associated with those businesses (hereafter collectively referred to as "ATC") I agree as follows: Although ATC has taken reasonable steps to provide me with appropriate equipment and skilled guides so I can enjoy an activity for which I may not be skilled, ATC has informed me this activity is not without risk. Certain risks are inherent in each activity and cannot be eliminated without destroying the unique character of the activity. These inherent risks are some of the same elements that contribute to the unique character of this activity and can be the cause of loss or damage to my equipment, or accidental injury, illness, or in extreme cases, permanent trauma or death. ATC does not want to frighten me or reduce my enthusiasm for this activity, but believes it is important for me to know in advance what to expect and to be informed of the inherent risks. The following describes some, but not all, of those risks. The hazards of walking on uneven terrain, slips and falls; slipping and falling on the rock wall, crashing on trampoline, falling from the swing, being hit by a ball or toy, falling from a chair, choking, allergic reaction; my own physical condition and the physical exertion associated with these activities.

I am aware that ATC entails risks of injury or death to any participant. I understand the description of these inherent risks is not complete and that other unknown or unanticipated inherent risks may result in injury or death. I agree to assume and accept full responsibility for the inherent risks identified herein and those inherent risks not specifically identified. My participation in this activity is purely voluntary; no one is forcing me to participate, and I elect to participate in spite of and with full knowledge of the inherent risks. I acknowledge that engaging in this activity may require a degree of skill and knowledge different from other activities and that I have responsibilities as a participant. I acknowledge that the staff of ATC has been available to more fully explain to me the nature and physical demands of this activity and the inherent risks, hazards, and dangers associated with this activity. I certify that I am fully capable of participating in this activity. Therefore, I assume and accept full responsibility for myself, including all minor children in my care, custody, and control, for bodily injury, death, or loss of personal property and expenses as a result of those inherent risks and dangers identified herein and those inherent risks and dangers not specifically identified, and as a result of my negligence in participating in this activity. I have carefully read, clearly understood, and accepted the terms and conditions stated herein and acknowledge that this agreement shall be effective and binding upon me, my heirs, assigns, personal representative, and estate and for all members of my family, including minor children.

IF THE PARTICIPANT IS A MINOR (UNDER 18 YEARS OF AGE)

I, as a parent or guardian of (print minors name)_____hereby give permission for Minor to participate in the activity and further agree, individually and on behalf of Minor to the above terms.

Parent/Guardian Name_____

Parent/Guardian Signature_____

Date_____

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ATTENDANCE POLICY

Appointments are scheduled into available standing appointment slots. Once you have been scheduled into an appointment time, the therapist has committed this time to you.

- If you are unable to keep a scheduled appointment, you must give ample notice (within 24 hours of the appointment time).

- Missing or cancelling (by call or text) any 3 appointments out of 5 continuous appointments will result in your child being immediately removed from the schedule.

- As in accordance with clinic policy and for the respect of patient, no children (other than those being treated by the therapist) are allowed in the gym or treatment rooms. Please keep any visiting children in the waiting area.

- If the parent or guardian leaves the clinic during the patient's session, they must return 5 minutes prior to the end of the session. Therapists and office staff cannot be held responsible for children beyond the scheduled therapy time.

- If your child is seen at preschool or daycare, and your child is not in attendance on the scheduled day of therapy, it is your responsibility to contact the therapist to inform them of a cancellation for that day,

Please Note: Therapists are only paid when your child is present. Due to limited scheduling availability, we ask that all patients attend their scheduled treatments. When an appointment is applied to our schedule, that time is reserved to meet your child's needs. We work hard to accommodate each of our patients. Continuous neglect to follow the regulations stated in this policy could lead to termination and/or change of status to your remaining treatments and/or sessions. Thank you in advance for your understanding and cooperation in this matter.

Signature_____ Date:_____

Printed Name_____

ADVANCED
THERAPY CLINIC LLC

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Patient Name_____

Authorization for Treatment

I consent to the treatment necessary for the above named patient, including physical therapy, occupational therapy, speech therapy, and/or any other related services that the provider or physician advise to be necessary.

Payment/Insurance Authorization

I authorize for all insurance/medicaid payments to be made directly to Advanced Therapy Clinic LLC for therapy services rendered. I acknowledge that I am financially responsible for all charges not covered by this assignment. I further acknowledge that my insurance company may limit therapy benefits. I will be responsible for all charges accrued if my insurance denies service. I authorize Advanced Therapy Clinic LLC to release to the Social Security Administration, its intermediaries or carrier's information needed for the claim or any related Medicare Claim.

If a balance remains unpaid 30 days after date of EOB, a $35 late fee will be charged. If unpaid after 60 days, the account will be transferred for collections.

If a Patients outstanding bill reaches $1000.00 (or more) Tx will be placed on HOLD effective immediately. Patients treatment time will be held for 2 weeks to allow for outstanding bill to be paid down 50% after which, treatment will resume. If the bill is not paid down to 50%, patient will be removed from schedule.

Thank you!

Please Print (Patient or Parent/Guardian)_____

Signature (Patient or Parent/Guardian)_____

Date:_____

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Patient Name_____

HIPPA Consent

I give Advanced Therapy Clinic LLC my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations such as quality reviews. Communication may be include, but is not limited to hospital, medical service company, health care company, insurance company, workers compensation carrier, welfare departments, patients employer, previous speech clinics, school teachers/aids/administrators. I have been informed that I may review the practice/clinic's Notice of Privacy Practices for a more complete description of uses and disclosures before signing this consent. I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic. I also understand that I may revoke this consent at any time by making a request in writing, except for information already used or disclosed.

All information obtained will be kept private and used only for the planning of services or for billing for services provided

Please list the names of service providers that may be contacted by Advanced Therapy Clinic LLC

Provider Name	Type of Provider (Physician, School, other therapists, Early intervention services....)

Please Print (Patient or Parent/Guardian)_____

Signature (Patient or Parent/Guardian)_____

Date:_____

ADVANCED THERAPY CLINIC LLC

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Thank you for taking the time to fill out this form as completely and honestly as possible. Your input plays an important role in the evaluation process. All the information on this form is confidential and will not be released without your permission.

IDENTIFYING INFORMATION			
Date:			
Person Completing Form:	Relationship to Patient:		
Patient's Name:	Patient Date of Birth:	Age:	Sex:
What do you hope to gain from this evaluation?			

FAMILY BACKGROUND	
Mother's Name & Age:	Father's Name & Age:
Occupation:	Occupation:
Work Phone:	Work Phone:
Is this child: ____ Your biological child ____ Adopted Child ____ Foster Child ____ Step Child	
If not your biological child, at what age did he/she come into your home:	
Person's living in the home (siblings, relatives, etc., please list ages):	
Does your child have a Medical Diagnosis? Yes No Please explain:	When was your child diagnosed
Does anyone related to this child have speech, language, hearing, learning, mental, medical, social, behavioral, or physical development problems? Y / N If yes, please describe who and what: Languages Spoken in Home _____ Are there any cultural or religious factors that may affect the child's treatment?	

BIRTH HISTORY

Length of pregnancy with this child: ____ weeks

Did mother experience any of the following during pregnancy?

- ☐ Excessive Illness
- ☐ Emotional Upsets
- ☐ Exposure to Drugs/Alcohol
- ☐ Flu
- ☐ Injury
- ☐ Marked Swelling of Hands/Feet
- ☐ Bleeding/Spotting
- ☐ Rh Incompatibility
- Other: _____

How would you describe the labor (check all that apply)?

- ☐ Easy Vaginal labor, spontaneous onset
- ☐ Vaginal birth
- ☐ Forceps/suction used
- ☐ Hard labor
- ☐ Breech presentation
- ☐ C-section delivery
- ☐ Induced labor

Condition of infant immediately after birth (Check all that apply)

- ☐ Normal, no problems
- ☐ Difficulty with feeding, sucking, swallowing
- ☐ Breathing problems
- ☐ Jaundiced
- ☐ Birth Injury
- ☐ Congenital differences

Measurements of the child: Weight _____ Length: _____

NICU Duration _____ Feeding tube Y /N Intubation Y / N

Did any of the following occur during infancy?

- ☐ Excessive Crying/Colic
- ☐ Difficulty Feeding/sucking/swallowing
- ☐ Injury
- ☐ Breathing problems/respiratory illness
- ☐ Other: _____ _____

If so, please explain:

HEALTH / MEDICAL HISTORY

Is the child currently in good health? ☐ Yes ☐ No

Is the child taking any medications? ☐ Yes ☐ No

If yes please list medication(s), dosage, and why used:

Has the child seen the following specialists? (Check all the apply)

- ☐ Neurologist
- ☐ Psychiatrist
- ☐ Ophthalmologist and/or Vision
- ☐ Orthopedic Surgeon
- ☐ Ear/Nose/Throat Specialist
- ☐ Psychologist
- ☐ _____

Explain reason child is seeing specialist(s):

Please include names of specialist(s) or where visits occurred:

Has the child ever had an operation or been hospitalized? ☐ Yes ☐ No

Dates/Surgery/Hospital:

Dates/Surgery/Hospital:

Do you have concerns regarding your child's hearing? ☐ Yes ☐ No

Does your child have a history of frequent ear infections? ☐ Yes ☐ No

If yes, number of ear infections per year:

When was your child's most recent hearing test?

Please list results of testing:

Does the child have any allergies? ☐ Yes ☐ No

If yes, please list:

COMMUNICATION DEVELOPMENT
Describe the child's communication difficulties:
Did the child make babbling/cooing sounds prior to saying words? ☐ Yes ☐ No
At what age did the child say his/her first word?
Does anyone have trouble understanding the child? ☐ Yes ☐ No
Does the child have difficulty producing specific sounds? ☐ Yes ☐ No
Does the child respond to speech and/or different sounds in the environment? ☐ Yes ☐ No
Does the child follow direction? ☐ Yes ☐ No If yes, please provide an example:
Does the child initiate communication with others? ☐ Yes ☐ No
Does the child talk ☐More ☐Less ☐The Same as children his/her age?
Does your child play and engage socially with other children his/her age? ☐ Yes ☐ No
Does the child play ☐With ☐Next ☐To Alone ☐or Avoid other children?
Does the child maintain eye contact while communicating? ☐ Yes ☐ No
How does the child communicate (gestures, single words, short phrases, etc.)? Please give examples:
How many words does your child typically put together in one utterance?
Does your child appear to be aware of his communication difficulties? ☐ Yes ☐ No If yes, please explain:

FEEDING HISTORY
Does your child have strong food preferences? ☐ Yes ☐ No Bottle fed Y/N Breastfeed Y / N If yes, please explain:
Does the child drool? ☐ Yes ☐ No
Does the child suck their thumb or use a pacifier? ☐ Yes ☐ No
Does the child have a strong gag reflex? ☐ Yes ☐ No
Has your child been to the dentist? ☐ Yes ☐ No <u>Does your child have an Oral Medical Diagnosis?</u> Cleft? ☐ Yes ☐ No Type _____ Tongue tie? ☐ Yes ☐ No Other _____

DEVELOPMENTAL HISTORY

Do you have any concerns regarding the child's motor development? ☐ Yes ☐ No
If yes, please explain:

Do you have any concerns regarding the child's emotional / social development? ☐ Yes ☐ No
If yes, please explain:

Do you have any concerns regarding the child's behavior? ☐ Yes ☐ No
If yes, please explain:

When did your child?
Roll Over _____ Crawl _____ Walk _____, Walk upstairs _____

How would you explain your child's personality?
Please add comments and/or attach any information that would be helpful in understanding the child's abilities:

ACADEMIC / THERAPY HISTORY

Does your child attend school? ☐ Yes ☐ No
If yes, name the school:

Issues at school? ☐ Yes ☐ No	Grade Level:	Name of Teacher:
Type of classes attended:		When did the child begin school?

Does your child receive other therapies (check all the apply)

Therapy ☐ Yes ☐ No
If yes, what kind?

Special Education Classes ☐ Yes ☐ No
If yes, what kind?

Special Testing ☐ Yes ☐ No
If yes, what kind?

List other therapists/specialist your child has seen:

Name /	Testing / Treatment Given	Year and month of service
_____	_____	_____
_____	_____	_____
_____	_____	_____