Alaska **Aquatic Therapy**

Physical • Occupational • Speech

POB 3313, Soldotna, AK 99669

General History

Child's Name: ______________________________ DOB: ____________ Date: ____________

Siblings Names and Ages: ____

____

Living Situation and Any Recent Changes: __________________________________

____

____

Is your child adopted or in foster care with you? Please describe previous home experiences:

____

____

When did you first become concerned about your child's development? What are your concerns for him/her? ____

____

What do you see as your child's strengths? ___________________________________

____

At what age did your child achieve these milestones?

Sitting Alone _________ Crawling _________ Walking _________ Babble _________

First Word _________ First Sentence _________ Drink from a Cup __________

Chew Solid Food __________

Medical History

Please describe if mother had any illnesses or complications during pregnancy or delivery. Include number of weeks of birth gestation: ______________________________

____

____

Vision – Has your child had their vision tested? What were the results? Does your child wear corrective lenses? ____

____

Hearing – Has your child had their hearing tested? What were the results? Has your child had any ear infections? ____

Child's Name: ______________________________

Feeding – Please describe if your child had any feeding problems as an infant: ______________

____

____

Was your child breast or bottle fed and for how long? ______________________________

____

Please describe if your child had colic or reflux as an infant: ________________________

____

Illnesses – List any allergies your child has: ____________________________________

____

Please describe and provide dates of any illnesses, medical issues, surgeries, procedures and hospitalizations your child has had:

____

____

Child Information

Please describe your child's personality: ____

____

____

How do you discipline issues at home? ____

____

____

Does your child have tantrums? How often? _____________________________________

Describe how your child handles changes to routine:_______________________________

____

____

Please describe your child's eating habits: _______________________________________

____

____

Please describe your child's sleeping habits/patterns: _____________________________

____

____

Please describe your child's toilet training history: _______________________________

____

____

Please describe your child's ability for dressing, bathing and grooming: _______________

____

____

What are your goals for therapy intervention for your child? ________________________

____

____

Personal Information

Child's Name: ______________________________ Date of Birth: ________ Age: ____ Male: ____ Female: ____
Child's Primary Physician: ______________________________ Person referring: __________________________
Is your child current with immunizations: ☐YES ☐NO If "No" give reason __________________________________
Medical Diagnoses (list all):____

Mother or Legal Guardian: ______________________
DOB: __________
Home Ph.: ___________________________________
Cell Ph.: _____________________________________
Work Ph.: ____________________________________
Physical Address: ______________________________
____
____
Mailing Address: _______________________________
____
____
Occupation: ___________________________________
Employer: ____________________________________
Address: _____________________________________
____

Father or Legal Guardian: __________________________
DOB: __________
Home Ph.: ____________________________________
Cell Ph.: _____________________________________
Work Ph.: ____________________________________
Physical Address: _______________________________
____
____
Mailing Address: ________________________________
____
____
Occupation: ____________________________________
Employer: ______________________________________
Address: _______________________________________
____

Child resides with? ___________________________ Who has custody of the child? _________________________
If primary person bringing child to therapy is not listed above, please list name and contact phone number of that person. ____

Insurance Information (Fill out all areas)

Primary Insurance: ____________________________
Policy Number: ________________________________
Group Number: ________________________________
Claims Address: _______________________________
Expiration: ________________________________
Phone Number: ________________________________
Insured's Name: _______________________________
Insured's DOB: ________________________________

Secondary Insurance: ____________________________
Policy Number: _________________________________
Group Number: _________________________________
Claims Address: ________________________________
Expiration: _________________________________
Phone Number: _________________________________
Insured's Name: ________________________________
Insured's DOB: _________________________________

Please Initial:
_______ I authorize KKT Inc. and/or ORS Inc to submit bills directly to the insurance carrier(s) for payment.
_______ I authorize insurance carrier(s) to make payments to KKT Inc. and/or ORS Inc.
Parent/Legal Guardian Signature ________________________________ **Date** ____________ ***Revised 10-25-11***

Child's Name: __________________________________

Emergency Contact Name (other than self): ________________________
Relationship: ___________________Phone______________________

Emergency Medical Release

Revised 10-14-13

In the event medical attention is required for your child while on the premises of KKT Inc. and ORS Inc., we need your authorization to implement treatment. Please read and sign the statement below.

As legal guardian of ______________________________, I give my permission for KKT Inc. and ORS Inc. to contact emergency personnel in the event of a medical emergency.
Parent/Legal Guardian Signature ____ **Date** ______________

Medication/Allergy/Condition:

Medication (include all vitamins, prescriptions, over the counter and homeopathic medications):

____

____

Allergies/Reactions/Food Intolerances:

____

____

Medical Conditions/Surgery (please list all conditions and surgeries that child has received):

____

____

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA):

- I acknowledge that I have received a copy of the Privacy Practices that state the rights of patients and/or a patient's parent/guardian.
  Initials ________ **Date** ________
- I hereby authorize any prior or present treating physician, therapist, school, hospital, infant learning program or other health institution to release all of medical information by any means of communication to KKT Inc. and ORS Inc.

Initials ________ **Date** ________
Child's Name: ______________________________

Please list all the names of providers and programs that have worked with or are currently providing services to your child. *In addition please provide us with the latest evaluations and/or IEP for your child.

Service	Program	Teacher/Therapist	Phone Number	Dates
Pediatrician				
Dietitian				
Infant Learning Program				
Day Care				
Preschool/Head Start				
School				
Occupational Therapist				
Physical Therapist				
Speech Therapist				
Counselor/Psychologist				
Case Worker				
Office of Children's Services				
Other				

Authorization and Consent for treatment, payment and operations:

Please Initial:

_______ I have a prescription/referral from my child's physician to authorize the initial evaluation.

_______ I have checked with my insurance company prior to this therapy visit and assert that I have obtained the necessary information regarding limits of coverage, co-pays and co-insurance.

_______ I hereby give Alaska Aquatic Therapy,Inc. permission to evaluate and treat my child, and understand there will be written, oral and electronic communication between care providers/physicians, insurance companies and KKT Inc. and ORS Inc. staff. I understand that state representatives for the purpose of insurance certification, licensing and quality assurance may review my child's records. I understand that all practices of confidentiality will be followed in use of the information gathered.

Parent/Legal Guardian Signature ____ **Date** ___________

Patient Name:	SSN:
AKA Name(s):	Date of Birth:

Person/Organization to receive information: ____________________________________

Person/ Organization to release information: ____________________________________

Description of information to be released: ______________________________________

I authorize the use and disclosure of health care and/or other information as described above:

- I understand that the Notice of Use of Private Health Care Information describes my rights and how my information will be used
- My authorization is voluntary, but a refusal to sign this authorization may affect my enrollment or eligibility, for benefits
- Because my records may contain sensitive information, the individuals and organizations named are limited to requesting and releasing the minimum amount of information necessary.
- My information to be released to others who must continue to keep this information confidential to the extend required by federal and state law.
- I may specify the length of time for my authorization to be in effect
- My authorization may be revoked at any time in writing on a form that states it is a revocation of my authorization, but the revocation will have no effect on actions that happened before it was received.
- I may request a copy of this signed authorization

This authorization expires on the following date or event____________________________

____ ________

Signature of named individual or legal representative Date

____________________________________ ________________________________

Printed name of legal representative or witness Description of representative's authority

PATIENT RELEASE OF INFORMATION AUTHORIZATION REQUIRED FOR ALL PATIENTS

HIPPA COMPLAINT

Patient Financial Policy

Thank you for choosing Alaska Aquatic Therapy. We understand that many patients find financial matters surrounding their medical care to be very complex and often confusing. If you have any questions, please ask to speak with our billing department.

Private Health Insurance	Initial Here ________	As the patient, you are responsible for requesting prior approval and/or out of network benefit level exceptions from your insurance company as required. Our office collects payments due at the time of service. You will be billed for any amount not covered by your plan in addition to your deductible, and/or co-insurance amounts not collected at the time of service.
Medicaid	Initial Here ________	We are a contracted provider with Medicaid. You must present a current card for each month of eligibility. Please note, a referral is required if you are in the Medicaid program, Without a referral you will be considered a self-pay patient.
Medicare	Initial Here ________	We are a contracted provider with Medicare. You must be enrolled in Medicare Part B to be eligible for benefits. You will be billed for any remaining deductible, co-insurance amounts and/or patient notified non-covered services after Medicare processes your claim.
Tricare Triwest VA	Initial Here ________	We are a network provider with Tricare and Triwest. We will bill Tricare and Triewest on your behalf as a courtesy. You will be responsible for any amount balance not covered by your plan. VA visits must be preauthorized by your referring physician.
Workers Compensation	Initial Here ________	We only accept Workers' Compensation claims that were filed with the Alaska Department of Labor.
Self-Pay Uninsured	Initial Here ________	Payment is due in full at the time of service unless other billing arrangements have been made by Alaska Aquatic Therapy.
Auto Accident	Initial Here ________	A claim must be established with your auto insurance carrier. We will only bill first party claims (your auto insurance) . Once your medical benefits are exhausted your private insurance may be billed. You must contact your private insurance to disclose your liability claim. If you have no other insurance, your account will be transferred to a self-pay status.

- ✓ I have read, understand and agree to this financial policy
- ✓ I understand that I am ultimately responsible for my balance, not my insurance carrier
- ✓ I authorize Alaska Aquatic Therapy to release medical information to my insurance carrier to facilitate payment
- ✓ I understand that my signature authorizes benefits to be paid directly to Alaska Aquatic Therapy
- ✓ I understand that should my account balance become delinquent, the balance may be referred to a collection agency.
- ✓ I will be held responsible for all fees associated with collection of my account balance.

Name of Patient:________________________________ Signature:________________________________

Date:____________

NO SHOW AND CANCELLATION POLICY

Alaska Aquatic Therapy is committed to providing all our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen. To serve you and others better:

PLEASE CALL OUR OFFICE BY 4:00PM ON THE DAY PRIOR TO YOUR SCHEDULED APPOINTMENT TO NOTIFY US OF ANY CHANGES OR CANCELLATIONS.

Failure to do so will result in a LATE CANCELLATION. The policy is as follows:

1st Late Cancel = Warning / Reminder of policy

2nd Late Cancel = $25.00 Fee

3rd Late Cancel = $25.00 Fee and Future Appointments cancelled

◯ I understand that if I fail to make my appointments or fail to cancel the day prior to 4:00pm, I risk a fee or cancellation of my future appointments.

◯ I have read, understand, and agree to uphold this written policy concerning cancellations and no shows.

____________________ ____________________________

Printed Name Signature Date