SUNNY HORIZONS INTAKE FORM

FIRST NAME

LAST NAME

NICKNAME

DATE OF BIRTH

SEX / GENDER

CONTACTS

PARENT / GUARDIAN FULL NAME

ADDRESS

CITY

STATE

ZIP CODE

PARENT / GUARDIAN PHONE

PARENT/ GUARDIAN EMAIL

EMAIL APPOINTMENT REMINDERS

☐ **YES** ☐ **NO**

SECONDARY CONTACT

SECONDAY CONTACT PHONE NUMBER

EMERGENCY CONTACT & RELATIONSHIP TO CHILD

EMERGENCY PHONE NUMBER

CONSENT FOR SERVICES

* **Please read and check <u>ONE</u> of the boxes and sign below.**

☐ I authorize Sunny Horizons, LLC to render appropriate evaluation and therapy services to the patient named above in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained health professional. I recognize, agree and understand that I have the right to refuse treatment or terminate services at any time by Sunny Horizons, LLC. In addition, Sunny Horizons, LLC may terminate services.

☐ I do not give my consent or am withdrawing my consent regarding Sunny Horizons, LLC rendering evaluation and therapy services to the client named above.

Parent / Guardian Signature

Date

INSURANCE

PRIMARY INSURANCE COMPANY

INSURED ID

GROUP NUMBER

GUARANTOR'S FIRST NAME

GUARANTOR'S LAST NAME

GUARANTOR'S RELATIONSHIP TO PATIENT

GUARANTOR'S DATE OF BIRTH

SECONDARY INSURANCE COMPANY

INSURED ID

GROUP NUMBER

GUARANTOR'S FIRST NAME

GUARANTOR'S LAST NAME

GUARANTOR'S RELATIONSHIP TO PATIENT

GUARANTOR'S DATE OF BIRTH

INSURANCE CLAIMS, PAYMENT POLICY & FEE SCHEDULE

Thank you for choosing our private practice to serve you. We are committed to providing you with the highest quality care. Please know that the timely payment of your bill is an integral part of our service and as such, this payment policy is an agreement between you and Sunny Horizons, LLC for payment of services provided. By signing this policy, you are agreeing to pay for services provided to you or your family members. As a client of Sunny Horizons, LLC you are required to carefully review and sign our payment policy.

As a courtesy to you, we will look up your insurance benefits and discuss your benefits with you. Please understand that not all benefits and exceptions are listed online and even if you have ST, OT, PT benefits, in some cases, your coverage may be based on medical need for the treatment due to a specific illness, injury or condition.

*** Knowing your insurance benefits is YOUR responsibility. Please contact your insurance company with any questions you may have regarding your coverage. ***

If you have a co-pay, co-insurance, or deductible, payment is expected at the time of service unless other arrangements have been made. Once your insurance company processes your claims, if there is a balance due, you will receive a statement from Sunny Horizons, LLC, for the amount you owe.

Please be aware that the balance of your claims is YOUR RESPONSIBILITY to know if your insurance company pays. Your insurance benefits are a contract between you and your insurance company; we are not a party in that contract.

PRIVATE PAY FEE SHEDULE (Effective 01/01/2023)

- Speech Therapy Evaluation $125 per evaluation / Speech Therapy Treatment $55 per half hour
- Occupational Therapy Evaluation $125 per evaluation / Occupational Therapy Treatment $55 per half hour
- Physical Therapy Evaluation $125 per evaluation / Physical Therapy $55 per half hour

Please read the following information carefully:

All therapy fees (including sessions fees and/or co-pays, if applicable) are due at the time of service or within 30 days.

We accept cash, card, or checks made payable to Sunny Horizons, LLC.

We will provide you with an invoice outlining the services rendered and the amount charged upon request and will email you a receipt of your payment.

*** Accounts 90 days past due will be referred to our collection agency and you will be responsible for any fees accrued as a result of the proceedings. ***

* **Please read and check ALL boxes to acknowledge and sign below.**

- ☐ I understand that I am responsible for all costs/fees that any third party (ex. insurance company, private school, etc.) does not cover. If a third-party payor source determines that rendered therapy services are "not covered" or otherwise denied, I will be responsible for immediate payment. I also understand that Sunny Horizons, LLC, will not become involved in disputes between you and your third-party source regarding uncovered charges or reasons for denial.

- ☐ I understand that if fees are not paid in full, treatment sessions may be postponed or cancelled until payment is received.

- ☐ I understand that all returned checks will be subject to a $30 returned check fee. Charges incurred and not paid after 30 days may be turned over to a collection agency at the client's expense. Overdue accounts may also be reported to a Credit Bureau.

- ☐ I understand that I am responsible for all legal and collection fees which Sunny Horizons, LLC, may incur if payment is not made in accordance with the terms and conditions herein.

- ☐ I understand that refunds will be issued only in instances of overpayment. All refunds will be processed within 2 weeks after the overpayment is discovered on the client's bill or at the time the refund is requested. Refunds for payments made with a credit card will be credited back by check. Clients who used a third-party source will not be issued a refund until full payment is received from the appropriate source.

- ☐ I understand the payment policy and the risks of not adhering to it.

Parent / Guardian Signature **Date**

HIPAA POLICY

Please list all people who are allowed to have information regarding your child, their relationship to your child, and their contact number.

NAME	RELATIONSHIP TO CHILD	PHONE NUMBER

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Treatment means providing, coordinating, or managing health care and related services, by one or more health care providers. An example of this would include a physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Healthcare operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer, Magnolia Hall, at mhall@sunnyhorizonsllc.org.

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

The right to inspect and copy your protected health information. The right to amend your protected health information. The right to obtain a paper copy of this notice from us upon request.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaints with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. Please contact The U.S. Department of Health and Human Services Office of Civil Rights for more information. They can be reached by email at OCRMail@hhs.gov or by phone at 800-368-1019.

We may contact you to provide appointment reminders, reschedule appointments, or provide information about treatment alternatives or health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorizations.

*** I have read and understand these terms.**

Parent / Guardian Signature **Date**

ACKNOWLEDGEMENT & ASSUMPTION OF RISK

*** Please read and check ALL boxes to acknowledge and sign below.**

- ☐ I understand that I am being asked to carefully read each of the provisions in the form. I acknowledge and agree to have my child receive therapy services rendered from Sunny Horizons, LLC, and/or any employee or independent contractor employed by Sunny Horizons, LLC.
- ☐ I acknowledge that there are some inherent risks associated with the use of therapy equipment that cannot be eliminated regardless of the care taken to avoid injuries.
- ☐ I understand the risks and I hereby assert that my participation is voluntary and that I knowingly assume such risks without holding Sunny Horizons, LLC, accountable for any losses, injuries or other damages occurring to the patient and/or myself. I further understand that I am fully responsible for my own safety.

_____ _____

Parent / Guardian Signature **Date**

CONSENT TO SCREEN PATIENTS FOR OTHER SERVICES

*** Please select ONE of the options below.**

- ☐ I give consent to Sunny Horizons, LLC, to screen, or informally assess, my child for other services offered at this practice location (which may include, but are not limited to, speech, occupational, or physical therapy). I understand that this screening is free of charge and completely voluntary and that I am not required to consent to a formal evaluation regardless of the outcome of the screening. I also consent to sharing pertinent medical information required to complete this screening with another discipline within the current practice location.
- ☐ I DO NOT give consent to Sunny Horizons, LLC, to screen, or informally assess my child for other services offered at this practice location (which may include, but are not limited to, speech, occupational, or physical therapy). I understand that this screening is free of charge and completely voluntary and that I am not required to consent to a formal evaluation regardless of the outcome of the screening. I also consent to sharing pertinent medical information required to complete this screening with another discipline within the current practice location.

_____ _____

Parent / Guardian Signature **Date**

CONSENT FOR STUDENT OBSERVATION / TREATMENT

*** Sunny Horizons, LLC, is proud to be a teaching facility. We are consistently accepting students to fulfill their program/college requirements for graduation.**

- ☐ I understand that a student (ST, OT, PT) may be present during my child's therapy. Depending on the level and experience determined by the program/college and the student's supervisor, they may perform hands on treatment under the supervision of the clinical supervisor employed by Sunny Horizons, LLC.

Parent / Guardian Signature **Date**

CONSENT & RELEASE OF PHOTOGRAPHS / VIDEOS

*** Please select all that apply.**

- ☐ I give consent to Sunny Horizons, LLC, or any party authorized by Sunny Horizons, LLC, to photograph and/or video record my child in connection with his/her therapy sessions, for any purpose subject to the therapist's discretion including, but not limited to, educational publication, for teaching purposes, and demonstration of progression of his/her skills.

- ☐ I authorize Sunny Horizons, LLC, to use pictures of my child for promotional purposes (ex. brochures, website, etc.).

- ☐ I acknowledge that I will receive no financial compensation for providing consent since my participation with Sunny Horizons, LLC, is voluntary.

- ☐ I hereby release Sunny Horizons, LLC, their contractors, their employees and/or any third parties involved in the creation or publication of Sunny Horizons, LLC. Publication from all liability that may arise in connection with the expressed and implied use of all photographs and videos outlined in this form.

OR

- ☐ I DO NOT give consent to Sunny Horizons, LLC, or any party authorized by Sunny Horizons, LLC, to photograph and/or video record my child in connection with his/her therapy sessions, for any purpose subject to the therapist's discretion including but not limited to educational publication, for teaching purposes, or demonstration of progression of his/her skills.

Parent / Guardian Signature **Date**

FOOD ALLERGIES / CONSENT FOR FOOD USE DURING THERAPY

My child is allergic to the following foods:

*** Please select the appropriate box(es) below.**

- ☐ I authorize Sunny Horizons, LLC, and its employees to use food during therapy with my child for the sole purpose of feeding therapy (for those patients who are referred for feeding).
- ☐ I authorize Sunny Horizons, LLC, and its employees to use food during therapy with my child as a motivator.

OR

- ☐ I do NOT authorize Sunny Horizons, LLC, and its employees to use food during therapy with my child.

Parent / Guardian Signature **Date**

OUTSIDE / PLAYGROUND THERAPY

*** Please select ONE of the boxes below.**

- ☐ I authorize Sunny Horizons, LLC, and its employees to take my child outside of the clinic building for therapy purposes.
- ☐ I DO NOT authorize Sunny Horizons, LLC, and its employees to take my child outside of the clinic building for therapy purposes.

Parent / Guardian Signature **Date**

FAMILY & SOCIAL HISTORY

*** What are your main concerns for your child?**

*** Are there any religious / holiday exemptions we should be aware of for your child?**

- ☐ **No**
- ☐ **Yes**

If yes, please explain.

*** People living at home with your child include:**

If your child has siblings, please list their names and ages:

*** Languages spoken or used in the home include:**

- ☐ **English**
- ☐ **Spanish**
- ☐ **Other: _____**

*** Is there a family history of speech, language and/or hearing difficulties in your family?**

- ☐ **No**
- ☐ **Yes**

If yes, please explain.

MEDICAL HISTORY

*** In the past, has your child been seen by any of the following? (Please check ALL that apply.)**

- ☐ Speech-Language Pathologist
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Nutritionist
- ☐ Audiologist
- ☐ ENT
- ☐ Other specialist(s): _____

*** Does your child have any activity restrictions?**

- ☐ No
- ☐ Yes

If yes, please explain.

*** Please list any medications your child may be taking.**

*** Please list any allergies your child may have.**

*** Do you have any hearing concerns for your child?**

- ☐ No
- ☐ Yes

*** Do you have any vision concerns for your child?**

- ☐ No
- ☐ Yes

*** Please check any of the illnesses listed below that your child has experienced.**

- ☐ Asthma
- ☐ Chicken Pox
- ☐ Croup
- ☐ Covid-19
- ☐ Colds
- ☐ Dizziness
- ☐ Draining Ear
- ☐ Ear Infections
- ☐ Encephalitis
- ☐ Headaches
- ☐ High Fever
- ☐ Influenza
- ☐ Mastoiditis
- ☐ Measles
- ☐ Meningitis
- ☐ Mumps
- ☐ Pneumonia
- ☐ Seizures
- ☐ Tinnitus
- ☐ Tonsilitis

If your child has experienced any serious illness NOT listed above, please list it in the box below.

PRENATAL & BIRTH HISTORY

*** Gestational Weeks at Birth?** _____

*** Did the mother experience significant illness or complications during pregnancy?**

- ☐ No
- ☐ Yes
- ☐ Unknown

If yes, please explain.

*** Did the mother experience significant illness or complications during or after birth?**

- ☐ No
- ☐ Yes
- ☐ Unknown

If yes, please explain.

DEVELOPMENTAL HISTORY

*** What was the approximate age your child:**

Began to crawl? _____

Began to sit alone? _____

Began to walk? _____

Said his/her first word? _____

Said 2+ words? _____

Was potty trained? _____

*** Does your child have feeding issues? (i.e. problems with sucking, swallowing, drooling, chewing, etc.)**

- ☐ No
- ☐ Yes

* **Does your suck his/her thumb?**
  - ☐ **No**
  - ☐ **Yes**

* **Is your child a mouth breather?**
  - ☐ **No**
  - ☐ **Yes**

* **Please describe your child's napping / sleeping patterns.**

SOCIAL DEVELOPMENT / HISTORY

* **Does your child play well with other children?**
  - ☐ **No**
  - ☐ **Yes**

* **Does your child adapt well to a new environment?**
  - ☐ **No**
  - ☐ **Yes**

* **Does your child respond when his/her name is called?**
  - ☐ **No**
  - ☐ **Yes**

* **What are some of your child's interests or hobbies? What motivates them?**

* **If your child attends school or daycare, please list any concerns your child's teacher may have.**

SPEECH / LANGUAGE DEVELOPMENT

* **How does your child communicate? (Please check ALL that apply.)**
  - ☐ **Gesturing / Pointing**
  - ☐ **Grunting**
  - ☐ **Babbling**
  - ☐ **Single Words**
  - ☐ **2 Word Utterances**
  - ☐ **3 Word Utterances**
  - ☐ **4 Word Utterances**
  - ☐ **Complete Sentences**

* **Can your child identify letters?**
  - ☐ **No**
  - ☐ **Yes**

* **Please describe how your child gets your attention. (i.e. tells you he/she is hungry)**

* **Does your child follow simple directions?**
  - ☐ **No**
  - ☐ **Yes**

When being read to, does your child do any of the following? (Please check all that apply.)
  - ☐ **Turn pages**
  - ☐ **Discuss characters**
  - ☐ **Hold the book**

Please comment on your child's writing skills.
