WyoKids Therapy
a division of Developmental Preschool & Day Care Center
OT ✶ PT ✶ SLP ✶ More...
Building brighter futures
Main Office: 1771 Centennial Drive, Laramie, WY 82070
Clinic Office: (307) 742-3571 Fax: (307) 742-6397
Website: http://wyokids.org

New Patient Intake Form

PERSONAL INFORMATION

Child's legal name: _____ Date of Birth: _____

Age: _____ Primary care/Pediatrician: _____

	Parent/Guardian 1	Parent/Guardian 2
Legal name		
Relationship to child		
Email Address		
Home/Cell Phone		
Work Phone		
Home Address		
Occupation		
Employer		
Employer Address		

EMERGENCY MEDICAL RELEASE

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

As legal guardian of _____, I give my permission for WyoKids Therapy to contact emergency personnel in the event of a medical emergency.

_____ _____

Parent/Legal Guardian Signature Date

EMERGENCY CONTACT (if different than above)

NAME: _____ PHONE: _____

RELATIONSHIP: _____

Who does the child reside with: _____

If primary person who will be bringing child to therapy is not listed above, please list their name, phone number, and relationship to the patient: _____

Child's name _____ DOB_____ Today's Date _____

Referred by: _____

Referral reason:

INSURANCE INFORMATION (please fill out ALL areas or provide copy of insurance cards)

Primary insurance: _____

Address: _____

Policy number: _____

Group number: _____

Insured's name: _____

Insured's DOB: _____

Secondary insurance: _____

Address: _____

Policy number: _____

Group number: _____

Insured's name: _____

Insured's DOB: _____

MEDICATIONS (include prescription drugs, over the counter meds, vitamins, and homeopathic medications):

ALLERGIES/REACTIONS:

History Information

Please answer the questions to the best of your ability and in as much detail as possible. Please add any information that you feel is important but is not covered on this form.

GENERAL HISTORY

Current concerns:

What are your primary goals for therapy?

Has your child previously received occupational, physical, or speech therapy? To address what concerns? Please include when, where, and for how long:

PREGNANCY & DELIVERY

Did the child's mother have any illnesses or complications during pregnancy or delivery? Please describe:

Child's name _____ DOB _____ Today's Date _____

Was your child premature? Yes ☐ No ☐ Born at how many weeks gestation: _____Birth weight: _____

Did your child require any medical procedures before, during, or after birth? Please describe:

DEVELOPMENTAL HISTORY

Please indicate at what age each major milestone was reached:

Sitting up by self: _____ Crawling: _____ Walking: _____ Jumping: _____ First word: _____

Two words together: _____ What was their first word? _____ What was their first phrase? _____

When did you first become concerned about your child's development?

MEDICAL HISTORY

Please describe illnesses, hospitalizations, or surgeries that your child has had and when they occurred:

Is there a family history of speech-language or other developmental delays?

Has your child had a neuropsychological evaluation? Yes ☐ No ☐ please provide copies of these evaluations at initial visit

If yes, date of most recent evaluation: _____Name of neuropsychologist: _____

SOCIAL HISTORY

Please describe your child's living situation (home, condo, apartment; # of people in household, stairs):

Sibling's names and ages:

If your child was adopted, please answer the following questions: Age of adoption: _____

Is your child aware of adoption? Yes ☐ No ☐

Previous home experiences prior to adoption:

EDUCATIONAL HISTORY

Grade: _____ Name of school: _____ Teacher: _____

Is your child on an IEP or 504 Plan? Yes ☐ No ☐

What services does your child receive? OT ☐ PT ☐ ST ☐ Counseling ☐ APE ☐ Vision ☐ Nurse ☐

Child's name _____ DOB_____ Today's Date _____

HEARING & VISION HISTORY

Has your child had his/her hearing tested? When? What were the results?

Has your child had any complications or procedures done to their ears (i.e. infections, tubes placed etc. include when)

Has your child had his/her vision tested? When? What were the results?

Does your child wear glasses or hearing aids?

Has your child participated in vision therapy? For what purpose?

PERSONAL INFORMATION

Please describe your child's personality:

What games, activities, and toys does your child enjoy?

Any other details we should know about your child:

List the names of the programs/people that work with your child outside of WyoKids Therapy.

SERVICE	PRACTICE NAME	PROVIDER NAME	LAST SEEN
Pediatrician/Physician			
Child care program			
Preschool			
School			
Occupational Therapist			
Physical Therapist			
Speech Therapist			
Counselor/Psychologist			
Other			

Child's name _____ DOB_____ Today's Date _____

Patient Authorizations

WyoKids Therapy offers Physical Therapy, Occupational Therapy, Speech-Language Pathology Services, Counseling, and Vision Services for patients referred to our practice. We are licensed providers who develop individualized treatment plans to identify the services that will best suit your child's needs. We work alongside your primary care practitioner and other service providers to coordinate your care.

Following an initial evaluation, we develop an individualized plan of care (POC) for review and approval by your child's referring provider. Once signed, we can begin implementing our plan/strategies to improve your child's level of function. We are grateful to provide these services for your child and encourage your feedback and input to alert us to anything we can do to help your child receive the highest quality of care.

We require certain information in order to begin providing care. The attached forms must be reviewed and completed in order for services to begin. If specific information does not apply to your child, please indicate "N/A" for not applicable so that we know you did not overlook anything.

Authorization and Consent for Evaluation, Treatment, and Clinic Operations: I consent to the rendering of medical care which may include routine diagnostic procedures and such medical treatment as the attending therapist(s) consider to be necessary. I may be offered medical services via telemedicine systems that involve the delivery of health care by electronic communication with a provider who is at a different physical location. I consent to initiating and/or receiving technology-based communications with my providers, including consulting services from a specialist performed virtually. I agree to be responsible for any charges that insurance does not pay. I understand that my medical care and treatment may be provided by licensed therapists and allied health students. I have read and understand this Authorization for Treatment and understand that no guarantee or assurance has been made as to the results that may be obtained.

TELETHERAPY AUTHORIZATION

Email for teletherapy: _____

Please initial the following OPTIONAL statements:

_____I give consent for my child to receive speech, occupational, physical, vision and/or counseling therapy via teletherapy when indicated.

_____I agree a parent, guardian, or caregiver will be present for teletherapy sessions to help facilitate treatments. This individual agrees to assist the child in understanding and using the technology and perform therapeutic interventions at the direction of the therapist. They shall be physically present with the child.

TECHNOLOGY AUTHORIZATION

Please initial the following OPTIONAL statements:

_____ I give permission for WyoKids Therapy to correspond with my child's legal guardians and care team via E-MAIL regarding treatment, documentation, and home programming. I understand that WyoKids Therapy email, once sent externally, may potentially be intercepted by an outside party.

_____ I authorize WyoKids Therapy to send text messages to my cell phone related to my child's therapy. I understand that communication via text message is not secure and may potentially be intercepted by a third party. I understand that standard data and text messaging rates will apply.

PHOTO AUTHORIZATION

Please initial the following OPTIONAL statements:

_____ I give permission for photos/videos of my child to be used for the purposes of treatment, education, and documentation.

_____ I give permission for photos/videos of my child to be used for advertising, brochures, and or web presences (i.e. website, Facebook, Instagram, Twitter etc.) specific to WyoKids Therapy. I understand I will be required to sign a model release prior to photos/videos being used.

Financial Policy: Welcome to WyoKids Therapy! We are committed to providing the highest quality of care to your children. If you have medical insurance, we are willing to help you receive your maximum allowable benefits. Therefore, we need your assistance and your understanding of our financial policies.

Payment, co-payments, deductibles, and co-insurance are due at EACH VISIT for charges incurred. We accept cash, checks, and credit cards. Please understand that you are financially responsible for all charges incurred, whether or not they are covered by insurance.

Please read carefully:

1. Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract. We will bill your insurance carrier; however, we cannot always guarantee a timely payment. If for any reason any portion of a bill is not paid by your insurance within 45 days from the date of service, you agree to make arrangements for prompt payment unless insurance contracts state otherwise or other arrangements have been made.
2. Should your insurance coverage change, our office should be notified within 10 days of the effective date and the cards must be available for copying. If you fail to provide us this information, your account and all future balances will be your

responsibility. We will be unable to bill insurance and you will become responsible for submitting claims. Payment will also be due at the time of services in full.

3. Not all services are covered benefits in all contracts. Some insurance companies select certain services they will not cover. These particular services, if any, are your responsibility. This office does not accept responsibility for negotiating settlements on disputed claims.
4. Past due accounts will be sent to collections after 90 days and all further services will be postponed until the account has been collected.

Our relationship is with YOU, not your insurance company. We realize that unexpected financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact our billing department promptly for assistance. This practice will not discontinue your child's services; for financial hardships, we are able to set up payment arrangements/plans. However, failure to follow through with payment plans will result in the discontinuation of services. If you have any questions or uncertainty about insurance coverage, please don't hesitate to ask. We are here for you!

Please initial the following statements:

_____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 give WyoKids Therapy permission to submit bills directly to my insurance carrier.

Cancellation Policy: Our clinic strives to ensure optimal use of therapy time. We understand occasional changes are necessary due to illness, vacations, or unexpected events. We ask that you discuss all schedule changes within 24 hours of a scheduled appointment. This allows us to accommodate clients in need of care into these additional openings. For Monday appointments, our office appreciates being notified Friday afternoon, but in the case of an emergency arising, please call and leave a voicemail so that we can plan accordingly once in the office.

We are happy to work out scheduling problems with you. Please let us know if you are having conflicts with your current schedule. If therapy needs need to be postponed for a few weeks due to family, financial, or other issues, we can hold your therapy spot for up to 3 weeks.

Please review and initial the statements below:

_____ I understand it is my responsibility to communicate to the clinic any schedule changes or appointment cancellations.

_____ I understand that if my child is more than 10 minutes late to an appointment, I must reschedule the appointment. If my child is late to more than 3 appointments, I understand I will be assessed a $10 administrative fee per successive late appointment.

_____ I understand that I must be present to pick up my child no later than 10 minutes before the scheduled end of their appointment. Administrative fees of $10 plus $1 for each minute late will be assessed for any children not picked up immediately. These fees are not covered by insurance and payment is required at time of pick up.

_____ I understand there will be a $10 fee for no notice of cancellation of the appointment. If my child misses more than 3 appointments without notice, their account will be put on a hold status for 1 month.

Authorization to Release Medical Information: I authorize WyoKids Therapy to release all medical information as necessary to: • All Payers for processing health care claims; • The person(s) I designate as my Billing Addressee/Guarantor for handling the billing, payment, and health care coverage for my account; • Accrediting and quality organizations, regulatory agencies, public health reporting agencies, or other persons or entities for health care operations; • My other health care providers for treatment or payment purposes. • I authorize WyoKids Therapy and my insurer(s) to share my past, current, and future health, treatment and account records about services I have received from WyoKids Therapy and other care providers as needed to manage or coordinate my care and to improve the quality of that care. • A health record locator service/health information exchange (HIE) allows my health care providers to electronically access my health information held by other participating providers to provide me with better care. I authorize WyoKids Therapy to access any of my health information that is available in an HIE, and WyoKids Therapy will also make my WyoKids Therapy health information available through HIEs in which it participates unless I opt out. If I opt out, by checking the box below, WyoKids Therapy will exclude all of my WyoKids Therapy health information from the HIEs in which WyoKids Therapy participates. ☐ HIE Opt Out

Authorization to Assign Benefits and Release Information: I authorize my Payer(s) to pay directly to WyoKids Therapy any benefits due under the terms of my health care plan(s), for services provided by WyoKids Therapy. I understand WyoKids Therapy reserves the right to refuse or accept assignment of medical benefits. If my health care plan(s) will not allow direct payment to WyoKids Therapy or if WyoKids Therapy chooses not to accept assignment of medical benefits, I agree to pay WyoKids Therapy all health care payments I receive for services. I authorize WyoKids Therapy to contact my Payer(s) to obtain all pertinent financial information concerning coverage and payments made under my health care plan(s) and for my Payer(s) to release such information to WyoKids Therapy. I hereby give WyoKids Therapy authorization to appeal on my behalf for services provided at WyoKids Therapy. I understand that this may waive my insurance appeal rights as a member when appealing the insurance denial. By signing this form, I understand that future appeal and adjudication rights for services may be exhausted according to the provisions of my plan.

Child's name _____ DOB_____ Today's Date _____

Statement of Financial Responsibility: I acknowledge I am responsible for all charges for services provided, including any amount not paid by my health care plan(s), or an out of state workers' compensation payer, other than billing terms and restrictions under a government program or as prescribed by law in Wyoming. I authorize WyoKids Therapy to apply any credit balance on my account to any amounts that I may owe. I agree that WyoKids Therapy may obtain financial information, including consumer credit reports to determine eligibility for financial assistance and/or payment options.

Dispute Resolution: I agree that any dispute (including personal injury claims) related to health care services rendered by WyoKids Therapy is subject to the exclusive jurisdiction of the appropriate court in the state where the provider of the disputed services is physically located when the services are rendered and the law of that state. Any state court action must be venued in the county where the provider of the disputed services is physically located when the services are rendered. These agreements also apply to my legal representatives and next of kin.

Use of Phone: I agree WyoKids Therapy, its affiliates and agents may use an automated telephone dialing system, pre-recorded messages, and texting, to contact the wireless number(s) and/or residential lines I provide to WyoKids Therapy for appointment and payment purposes.

Notice of Privacy Practices: I acknowledge I have been presented with the WyoKids Therapy Notice of Privacy Practices, which can be viewed at: http://therapy.wyokids.org. I can request a paper copy during my visit or by calling 307-742-3571.

Attention: This is a legal document. Changes will not be accepted on this form. Requests for any alterations must be made by calling at 307-742-3571. By signing, I agree that I understand and accept all the terms on this form. I understand I have the right to revoke the authorizations on this form at any time by notifying WyoKids Therapy in writing, except to the extent that WyoKids Therapy has already taken action in reliance upon them. These authorizations will remain valid until I revoke them in writing.

• If the patient is 18 years of age or older, the patient must sign and date the form.

• If the patient is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form. Indicate your legal authority and include documentation of your relationship: Legal Guardian or Conservator Health Care Agent (Health Care Power of Attorney) Other Legal Representative

• If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law.

Indicate your relationship: _____

_____ _____ _____

Parent/Legal Guardian Signature (required) Date (mm-dd-yyyy) Time (hh:mm) am pm

_____

Printed Name of Person Signing (if not patient) (First, Middle, Last)

Child's name _____ DOB_____ Today's Date _____