PATIENT INFORMATION

Name: _________________________ DOB: ____________________

Address:____
____________________Zip:___________________

Email address: ____

Phone: (home) _____________________________
(cell) _______________________________
(work) ______________________________

Emergency Contact: ______________________ Phone #: ______________

Reason for referral / Primary concern:
____
____

Attending physician's name: ______________________ Phone:_____________________
Address: _______________________________________ Zip: _______________________

Do you have a prescription/letter of recommendation from physician? Yes No

Do you have a report from physician? Yes No therapist? Yes No

How did you find us? (circle)
Physician Friend Insurance Internet School Other__________
____

Person responsible for payment:
Name: _______________________________ Phone: ________________________

Address: ____ Zip: __________________

SS#: __________________________________

Developmental History
Adults and Adolescents

General Information

Name:____

(first) (last) (nickname)

Birth Date:____

Occupation: ____

Highest education completed: ____

Have you received previous evaluations and/or treatment by an occupational therapist? □ Yes □ No

If yes, when and where: ____

Referred by: ____

Address: ____

Profession: ____

Reason for referral: ____

What do you hope to gain from this evaluation and/or treatment? ____

____

____

Medical History

Medical diagnosis (if any): ____

Have you had a vision test recently? □ Yes □ No If yes, when? _________________________________

Are you color blind? □ Yes □ No

Have you had a hearing test recently? □ Yes □ No If yes, when? ________________________________

What were the results of hearing and vision tests? ____

____

____

Have you had any of the following? If yes, describe and give any pertinent dates.

Childhood diseases or major illnesses: ____

Congenital abnormalities: ____

Seizures: ____

Ear infections: ____

Allergies: ____

Asthma: ____

Hypertension: ____
Casts or braces: ____
Surgery: ____
Serious injury: ____
Other: ____
____
____
List any medications you are currently taking: ____
____
List any medication you have recently taken but are not currently taking:
____
____

Are there any medical precautions the therapists should be aware of when working with you? □ Yes □ No
____
____
____
Have you received other evaluations or treatment (psychological, speech, language, neurological, other?)
□ Yes □ No If so, what type, when and by whom?

Type:	Eval Date:	Professional's Name:	Dates of therapy:

Childhood Developmental History

The following questions are about your birth and childhood history. While you may not have access to much of this information, please answer whatever questions you have knowledge of. **Childbirth – were you:**

1. **Full term baby?** □ Yes □ No If premature, number of weeks: ____________________________
2. **Breeched (feet first)?** □ Yes □ No
3. **Require intensive-care hospitalization?** □ Yes □ No How long: __________________________

Childhood Developmental History

As a child did you:

1) Have feeding problems (such as trouble using a bottle, learning to use spoon, or drink from cup)?

□ Yes □ No If yes describe: ____

____

2) Have sleeping problems? □ Yes □ No If yes, describe: _______________________________________

____

Developmental Milestones

Mark as late [L], early [E], or average [A] if known, and comment on anything unusual.

Walk		*Drink from a cup*	
Chew solid foods		*Crawl*	
Say words		*Sit alone*	
Roll over		*Say sentences*	

Comments:

____

____

____

____

Did you have trouble learning bowel and bladder control? □ Yes □ No

Cognitive/Attentional Skills

Do/did you have difficulty in any of the following?

□ Reading □ Math □ Spelling □ Handwriting

□ Gym class □ Following directions □ Finishing tasks □ After-school sports

□ Remembering information □ Paying attention □ Organizing work □ Restlessness

□ Other ____

____

____

Do/did you ever receive any special education services? □ Yes □ No If yes, describe: __________________

____

Handedness: □ Left □ Right □ Mixed dominance

1. Do you have specific fears? □ Yes □ No If yes, please describe: ______________________________
____
____

2. Are you concerned you may have a medical/psychological problems? □ Yes □ No
If yes, please describe: ____
____
____

General State of Arousal

Please share your thoughts on each of the following as they pertain to you:

Activity level: ____
____

Attention Span: ____
____

What do you do to help yourself pay attention? ____
____

Stress level: ____
____

What do you do to help yourself calm down? ____
____

Body temperature regulation (for example, overheat easily):
____
____

Sleep Patterns

Do you?

1. Have regular sleep patterns? □ Yes □ No If yes, please describe: ______________________________
____

2. Wake frequently during the night? □ Yes □ No If yes, please describe: ____________________________
____

3. Tend to be an early riser, up and on the go? □ Yes □ No

4. Have difficulty falling asleep? □ Yes □ No

5. What kind of things do you do to help yourself wake up? ____
____

6. What kinds of things do you do to help yourself fall asleep? _____________________________________
____

Hobbies/Pastimes

1. Do you have any hobbies? □ Yes □ No If yes, please describe: ______________________________
____
____
2. What are your favorite pastimes? ____
____
____
3. What activities do you least enjoy? ____
____
____

Performance

What is your ability to: (some questions apply to only one sex)	Unable	Not Attempted	Fair	Average	Good	Comments
Whistle?						
Blow a bubble with bubble gum?						
Drink through a straw?						
Blow a balloon?						
Use a razor for shaving?						
Use dental floss?						
Jump off the ground with both feet together?						
Pump on a swing?						
Kick a ball?						
Hop on one foot?						
Ride a bicycle?						
Jump rope?						
Skip with both feet?						
Rollerblade or ice skate fluidly?						
Snow ski?						
Do jigsaw puzzles?						
Cut with scissors?						
Tie laces or a ribbon?						
Wrap a present?						
Manipulate snaps, buttons, and buckles?						
Cut with a knife?						
Snap fingers?						
Operate a can opener (manual/electric)?						

Put a belt through all belt loops?						
Tie a man's tie?						
Type on a computer?						
Play games on a hand held device?						
Use a cordless or touch tone phone?						
Put in contact lenses?						
Put on aftershave all over face?						
Polish shoes with shoe polish?						
Open and close an umbrella?						
Use a copier machine?						
Reload paper in a fax machine or printer?						
Use a coffee maker?						
Swim using the crawl or other strokes with coordinated breathing?						
Float on back and stomach in the water?						
Change a tire?						
Back up while driving?						
Parallel park?						
Apply makeup?						
Style your hair?						
Put on pierced earrings and/or necklace?						
Put on a watch?						
Blow dry hair?						
Blow nose?						
Zip the zipper on a coat?						

1. What methods do you find most helpful to learn new tasks? ______________________________________
____
____

2. How have difficulties you are experiencing in any of the above areas affected your life? ______________
____
____

3. Are there any particular skills you would like to be able to achieve? ________________________________

____

____

4. Do you or anyone else in your family have similar difficulties? If so, please describe below and/or mark pertinent section of the questionnaire in a second color. ____________________________________
____
____
____

Printed name: _______________________________

Signature: __________________________________ Date: _____________________________

INSURANCE INFORMATION

PATIENT INFORMATION

Patient Name:	Date of Birth:	Sex: M F

RESPONSIBLE PARTY INFORMATION

Name:	Relationship:	
Address:	Sex: M F	
City:	State:	Zip:
Home Phone:	Work Phone:	
Social Security No:	Employer:	

INSURANCE COMPANY INFORMATION

Primary Insurance Co:	I.D. Number:	
Group Number:	Policy Number:	
Address:	City:	Zip:
Phone:		
Subscriber's Name:	Employer:	
Relationship to Patient:	Date of Birth:	
Secondary Insurance Co:	I.D. Number:	
Group Number:	Policy Number:	
Address:	City:	Zip:
Phone:		
Subscriber's Name:	Employer:	
Relationship to Patient:	Date of Birth:	

RELEASE OF MEDICAL INFORMATION

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original.

Date: Signature:

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to signed physician or supplier for services described on health insurance claim forms. I also understand that this assignment of benefits is irrevocable and a photo static copy shall be considered as legal and binding as the original.

Date: Signature:

PAYMENT POLICY

All payment for professional services rendered are due at time of service, unless insurance is applicable. We will file insurance, but all co-pays, co-insurance, and deductibles are due at time of service. Services not covered and balances remaining will be billed to the responsible party.

Date: Signature:

Patient's Name: ______________________________
DOB: ________________

Authorization for releasing and acquiring information:
I, the undersigned, authorize Capital Therapy Group to acquire and/or release professional information from and to my physician and/or other personnel involved in the evaluation and management of requested services.

____
Signature

____
Printed Name/ Relationship to Patient

____
Date

Authorization for audio recording and/or videotaping:
I grant permission to be videotaped and/or audio recorded during a therapy session. I understand that this video/audio recording will be used to establish baseline criteria and may be analyzed at any time by the treating speech therapist, occupational therapist, or physical therapist. Audio and/or videotaping with *will not be shared with any other parties and will only be used for the purpose of analyzing skills for therapy goals.*

____
Signature

____
Printed Name/Relationship to Patient

____
Date

SCHEDULING PAYMENT AND INSURANCE POLICIES

Scheduling:
Your scheduled therapy time is a reserved time for you and your therapist. Your therapist spends a great deal of time and effort preparing for your therapy session. If you must cancel a therapy session, we ask that you give at least 24 hours notice. ***Less than 24 hours notice for cancellations (last minute cancellations) and not showing up for an appointment (no shows) will be charged a $40 fee. These charges will not be filed with your insurance company and will be your full responsibility for payment.***

Consistency in therapy attendance is absolutely necessary for you to make progress. If you find it necessary to cancel therapy sessions frequently, we will ask that you schedule therapy at a more convenient time so that therapy may be provided on a consistent basis.

If you should need to cancel your appointment for 3 of 5 scheduled appointments, or no show more than 2 times, you will automatically be removed from the schedule and put on a wait list for a time easier for you to attend consistently.

There will be times when your therapist will need to cancel therapy. You will have an opportunity to re-schedule the session or cancel the session.

Therapy sessions are scheduled back to back throughout the day. We try to begin and end therapy promptly. Please be on time for your appointment. If you are late for an appointment, it will be necessary to shorten you therapy visit.

Any questions or concerns you may have regarding your therapy or other issues of the office may be directed to Susan Weber. You may reach Susan by phone 512-331-4115 or by email at sweber@austinctg.com.

____
Signature Date

Payment:
Payment is due at the time services are rendered. You may choose to pay weekly or monthly if you make arrangements with the front office. Fees owed past 30 days will need to be paid immediately or your appointments will be cancelled until payment is received.

Payment is due in full for all services rendered until insurance coverage is verified. Once insurance coverage is verified, you will be expected to pay your co-pay weekly. If payment is not received from your insurance company within 60 days of billing, you will be responsible for payment in full.

If Capital Therapy Group is filing insurance claims for you or if you are paying privately, a statement will be provided to you for any balance due by you. Please note there will usually be a 4 to 8 week delay between the date services are rendered and the response from your insurance company. This delay is due to the time it takes your insurance company to process claims filed. Therefore, your statement will reflect this delay if you have not paid your balance in full. Questions regarding insurance claims, charges and payments should be directed to Sylvia Johnson by phone at 512-331-4115 or by email at sjohnson@austinctg.com.

____

Signature Date

Insurance:

Insurance is a contract between you and your insurance company. Capital Therapy Group will file insurance claims and provide assistance in filing necessary paperwork when claims are denied but ultimately terms of reimbursement are between you and your insurance company. If for any reason, insurance does not reimburse at the anticipated rate, the patient is responsible for all expenses incurred.

If you change insurance companies, it is your responsibility to let the office know of the change and to provide a copy of the new insurance card on or before that new coverage begins. Failure to give the necessary information on or before coverage begins, may result in your responsibility for all fees incurred for services provided during that time. Questions regarding your coverage, benefits and denials should be directed to your insurance company.

____

Signature Date

CAPITAL THERAPY GROUP

Acknowledgement Of Receipt Of Notice Of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices.

____
Print Name

____
Signature

____
Relationship to Patient

For Our Office Use Only

Our office attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained for the following reason:

_______ Patient refused to sign
_______ Communication barriers prohibited obtaining the acknowledgement
_______ An emergency situation prevented us from obtaining acknowledgement
_______ Other (Describe below)

____
____
____

CAPITAL THERAPY GROUP

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this Notice please contact our Privacy Officer.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. We are required by Federal law to give you this Notice and to maintain the privacy of your health information. We must also abide by the terms of this Notice while it is in effect. We reserve the right to change our privacy practices and the terms of this Notice at any time. Before we make significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request.

Uses and Disclosures of Protected Health Information

You will be asked to sign an **Acknowledgement of Receipt Of Notice Of Privacy Practices.** Once you have received our Notice of Privacy Practices, disclosures of your protected health information will be used for treatment, payment and health care operations. Your protected health information may be used and disclosed by our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of practice. Following are examples of the types of uses and disclosures of your protected health care information that our office is permitted to make.

Treatment: We will use and disclose your protected health information to other health care providers to provide, coordinate, or manage your health care. For example, your protected health information may be provided to another health care provider to whom you have been referred to ensure that the necessary information is available to diagnose or treat you.

Payment: Your protected health information will be used to obtain payment for services we provide to you. This may include certain activities that your insurance plan may undertake before it approves or pays for the services we recommend.

Healthcare Operations: We may use or disclose your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, credentialing activities, conducting training and conducting other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your provider. We may also call you by name in the waiting room when your speech pathologist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointments.

Business Associates: We will share your protected health information with third party Business Associates that perform various activities (billing services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the

services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that our practice has already taken an action as provided for in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then we may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Family and Friends: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information to the extent necessary to help with your healthcare or with payment for your healthcare. We will also use our professional judgment to make reasonable decisions in your best interest in allowing a person to pick up health forms of health information.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent

Required By Law: We may use or disclose your protected health information when we are required to do so by law.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your Acknowledgement of Receipt Of Notice Of Privacy Practices as soon as reasonably practicable after the delivery of treatment. In the event of your incapacity or an emergency, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim or other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health and safety of others.

Military Activity and National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody, the protected health information of inmates or patients under certain circumstances.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance.

Your Rights

You have the right to inspect and copy your protected health information. You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make the request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you prefer, we will prepare a summary or an explanation of your health information for a fee.

You have the right to request a restriction of your protected health information. You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in an emergency.

You have the right to request alternative communications from us. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

You have the right to request an amendment to your health information. You have the right to request that we amend your health information. Your request must be in writing. The request must explain why the information should be amended. We may deny your request under certain circumstances.

You have the right to receive an accounting of disclosures we have made of your health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost based- fee for responding to these additional requests.

You have the right to make a complaint about our privacy policies. If you are concerned that we have violated your privacy rights, you may file complaint with our Privacy Officer using the contact information listed at the bottom of this page. You may also file a written complaint with the Department of Health and Human Services. We will provide you with their address upon request. We will not retaliate against you for making a complaint to either our office or the Department of Health and Human Services.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Effective Date: January 21, 2013

Privacy Officer: Susan Weber

Telephone: (512) 331-4115

Fax: (512) 331-8176

Email: info@austinctg.com

Address: 13642 North Highway 183, Bldg. 2, Ste. 200