Personal Touch Therapies, P.C.

P.O. Box 630001, Littleton, CO 80163-0001 Phone: (303) 660-6493

CLIENT INTAKE

How did you hear about us? Friends / Family Name:_____

Social Media / Website / Google / Other describe:_____

PATIENT

Child's Full Name:_____ Date of Birth:_____ Sex: M / F

Address:_____ City:_____ Zip:_____

GUARDIAN(S)

Guardian's Name (1)_____ Phone: _____

Address:_____ City:_____ Zip:_____

Guardian's Name (2):_____ Phone:_____

Address:_____ City:_____ Zip:_____

Personal Touch Therapies, P.C. can leave a message with Protected Health Information (including child's name and dates/times of appointments) on my:

Cell Phone:_____ Email:_____

DOCTOR(S)

Physician/Pediatrician (Name and Facility)_____

Address:_____ Phone:_____

Other Physician (Name and Facility):_____

Address:_____ Phone:_____

My therapist may take photos or videos of client throughout the treatment to enhance the rehabilitation and track the progress.

Client/Guardian signature: _____ Date: _____

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INSURANCE

PRIMARY Insurance Name:_____ Plan Name:_____

Address:_____ Phone:_____

Group #_____ ID #_____

Policy Holder Name:_____ Policy Holder DOB:_____

Policy Holder Address:_____

Policy Holder Employer:_____

Relationship to Patient:_____

SECONDARY Insurance Name:_____ Plan Name:_____

Address:_____ Phone:_____

Group #_____ ID #_____

Policy Holder Name:_____ Policy Holder DOB:_____

Policy Holder Address:_____

Policy Holder Employer:_____

Relationship to Patient:_____

PROVIDE INSURANCE CARD

MEDICAID

Medicaid #:_____ Primary / Secondary

PROVIDE MEDICAID CARD

By Signing below, I acknowledge that all of the above information is true and accurate. If at any time any of this information changes, I am aware that I must inform Personal Touch Therapies immediately.

Guardian:_____ Date:_____

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FINANCIAL AGREEMENT

_____ Initial

INSURANCE: As a courtesy to its patients Personal Touch Therapies, P.C. will bill the Patient's insurance company. A client/guardian's insurance policy is a contract between the patient and the insurance carrier. The patient/guardian is responsible for all fees regardless of Insurance coverage. If the insurance has failed to pay we expect the client/guardian to pay the bill. If problems with the insurance company arise it is the responsibility of the client/guardian to establish communications with the insurance company.

_____ Initial

AGREEMENT TO PAY: The client/guardian agrees to pay for all services rendered. In the event that my insurance reduces payment or denies payment, I will be financially responsible to pay. Personal Touch Therapies will provide a monthly invoice for payment. I agree to make full payment within 30 days of the billing.

If a collection agency's services are required, I further agree to pay for all legal fees, court costs, reasonable attorney fees, and collection agency fees in connection to my debt. If the debt is not paid within 45-days we will begin to incur interest at the rate of 1.5% monthly or 18% annually until the debt is paid. I also understand that in order to collect my debt, my credit history may be affected.

_____ Initial

CO-PAYMENTS and DEDUCTIBLES: It is the client/guardian's responsibility to pay for their co-payments and their applicable annual deductibles.

_____ Initial

MEDICAID: Personal Touch Therapies, P.C. is a Colorado Medicaid provider. Personal Touch Therapies, P.C. will file your claim with Medicaid. If Medicaid is secondary billing, Personal Touch Therapies, P.C. will bill the Insurance first. If Insurance denies, then Medicaid will be billed.

_____ Initial

CANCELLATION: If a session must be cancelled, at least 24 hours in advance should be provided. Unforeseen events occur that may prevent the 24-hour cancellation; however, please call to cancel all appointments.

GUARDIAN/RESPONSIBLE PARTY RESPONSIBILITY

I have read and understand the financial policy of Personal Touch Therapies, P.C. By signing this form, I consent to the above terms and conditions of treatment and understand that it is my responsibility for assuring that the financial obligation of my care is fulfilled.

I hereby authorize payment by my insurance carrier or other designated payer of medical benefits to Personal Touch Therapies, P.C. This assignment will remain in effect until revoked by me in writing. I hereby accept financial responsibility for all charges incurred whether or not I have insurance coverage. I also authorize Personal Touch Therapies, P.C. to release to my insurance carrier or their agents any medical information about me needed to determine these benefits or the benefits payable for service.

Guardian/Responsible Party:_____ Date:_____

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HISTORY

Child's Name:_____ DOB:_____ Age:_____
Is your child adopted or a foster child? YES / NO

Describe your concerns about your child's development: _____

_____

_____

Birth History

During pregnancy did the mother experience (circle all that apply):

Hemorrhaging	Drug use	Alcohol use	Smoking	Diabetes
High blood pressure	Elevated lead levels	Hospitalization (explain) _____		

Child was born: Full-term / Premature If premature, how many weeks:_____

Were there any complications:_____

Education

Does child attend daycare /school Name:_____

Special services received in school: OT / PT / Speech / Other:_____

Medical History

Is there a Medical diagnosis:_____

Hospitalizations:_____

Surgeries:_____

Medications:_____

Allergies:_____

Circle all that apply:

Chronic illness	Chronic infections	Heart defect	Seizures
Trach	Balance	Hearing Aids	Wears glasses
C-Line	Physical injuries	Hearing difficulty	Vision problem
G-tube			

Special equipment used:Splints / Braces / Adaptive / Other:_____

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Behavior (circle all the apply):

Cries often	Frequent temper tantrums	Dislikes hair brushing
Anxious	Avoids touch from others	Dislikes playground equipment
Clumsy	Trouble following directions	Poor attention span
Weak muscles	Rocks self	

Fears, Coping behaviors:_____

List other therapies your child is receiving or has received:

Type of Therapy	Frequency	Name of therapist	Therapist phone #
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Additional information regarding care, contact and restrictions:_____

_____

_____