BEYOND BOUNDARIES
THERAPY SERVICES

Client Intake Form

Client Name _____ DOB _____/_____/_____ ☐ Female ☐ Male

Client Address _____

City_____ State_____ Zip_____

Phone _____ Email _____

Please indicate who Beyond Boundaries may communicate with regarding this client's therapy care including schedules and updates (check all that apply). Billing information will be shared only with mother, father, or legal guardian as authorized.

Mother's Name _____ ☐ N/A

Father's Name _____ ☐ N/A

Other Legal Guardian _____ ☐ N/A

Other _____ _____ ☐ N/A

INSURANCE

****A copy of the front and back of your updated insurance card(s) are required to be on file at Beyond Boundaries****

Primary Insurance _____ ID# _____

Policy Holder _____ DOB _____

☐ No ☐ Yes, Secondary Insurance _____ ID# _____

Policy Holder _____ DOB _____

☐ No ☐ Yes, Third (Tertiary) Insurance _____ ID# _____

Policy Holder _____ DOB _____

CONTACTS

In case of an emergency, contact _____ Relationship _____

☐ Cell _____ ☐ Work _____ ☐ Home _____

☐ N/A Respite Worker Name _____ Phone _____

☐ N/A Foster Parent(s) Address _____

Foster Mother _____ Phone _____

Foster Father _____ Phone _____

For adult clients, name of caregiver who will attend sessions:

Name _____ Phone _____

School client attends _____ Phone _____

Does client have an Individualized Education Plan? ☐ No ☐ Yes (please provide a copy to Beyond Boundaries)

Other than parents / legal guardian, who do you authorize to pick up this client?

Name _____ Phone _____

Name _____ Phone _____

APPOINTMENT REMINDERS

Beyond Boundaries Therapy cancellation / no-show policy indicates: **Cancellation**: If it is necessary to cancel a therapy session, you must provide a 4-hour advanced notice or a charge of $50 per missed therapy session will be billed. The exceptions to this would be; **unexpected illness, family emergency, and inclement weather**. If illness affects the client's treatment plan, a physician's note will be required. **If you reschedule this appointment within 5 business days, there will be no charge.**
No-Show: If a client does not attend a scheduled therapy session a fee of $50 per therapy session will be charged (this includes schools, daycares, and home visits). More than 3 no-shows per therapy could result in discharge from that service.

As a courtesy, Beyond Boundaries provides appointment reminders to help avoid unplanned cancellations and no-shows. Please indicate below how you would like to be reminded of appointments.

☐ I am aware of the above fees, however, would NOT like a reminder for appointments.

I would like a reminder sent to me by:

☐ Email _____

☐ Voice Reminder Call to Phone __(_____)_____

☐ Text Reminder __(_____)_____ Cell phone Carrier _____

If opting to choose text reminder, please be aware that message and data rates may apply. If you have an unlimited text messaging plan, then you don't have to worry.

We are happy that you have chosen Beyond Boundaries Therapy Services. Who can we thank for referring you?

☐ Self ☐ Website ☐ Facebook ☐ Web search ☐ Other _____

☐ TV ☐ Magazine (which one) _____ ☐ Radio (which station) _____

☐ Medical Professional
☐ Friend/Family
☐ School/Daycare

Name: _____

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Beyond Boundaries Occupational Therapy, Inc. (Occupational Therapy & Physical Therapy) and Beyond Boundaries Speech Language Therapy, Inc. for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, not covered by insurance, and for all services rendered on my behalf or my dependents. I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Printed name of responsible party_____

Signature of responsible party_____ Date _____

BEYOND BOUNDARIES
THERAPY SERVICES
3001 11TH St. So., P 701.356.0062
Fargo, ND 58103 F 701.356.5412

ADULT
Needs Assessment / Case History

Form Completed by: _____

Name: _____ DOB: _____ Age: _____ Gender: Male/Female

Doctor: _____ Date of Last Doctor Visit: _____

Current physician(s): _____

Current Medical Diagnoses:_____

Allergies: _____

Sleep: Hours per night _____ Naps (# and length) _____ Any difficulty with sleep _____

Current medication(s) including supplements and over the counter medications:_____

Any recent accident / injury / incident (within the last 6 months): _____

Any hospitalizations / surgeries (include dates): _____

Current physical limitations: _____

Are there any precautions or contraindicated activities _____

Special equipment or assistive technology that you use: _____

If so, please bring with you at the time of the evaluation.

PAST THERAPY

Have you received previous therapy evaluation and/or treatment: _____ no If yes → ____ OT ____ PT ____ Speech

If so, when? _____ where?_____ for how long? _____

Goal areas addressed _____

Response to past therapy intervention _____

CLIENT RESPONSE:

My strengths are _____

I enjoy _____

I wish it were easier to _____

What would you like to learn from this evaluation?_____

What is your primary concern at this time?_____

CAREGIVER CONCERNS (if applicable):

What would you like to be easier for you? _____

What would you like to learn from this evaluation?_____

What is your primary concern at this time?_____

BEYOND BOUNDARIES
THERAPY SERVICES
3001 11th St. So., Fargo, ND 58103
701-356-0062

HIPAA Disclosure Form / Notice of Privacy Practices

CLIENT NAME:_____ CLIENT DOB: _____

We consider the privacy of health information to be one of the most important elements in our relationship with you. Our responsibility to maintain the confidentiality of your health information is one that we take very seriously. We have taken the following steps to protect your privacy. We train our staff members on their responsibility to maintain the confidentiality of your health information and hold them accountable for their actions. We do not sell your information to any organization. Federal legislation concerning patient privacy requires health care providers, health insurance companies and other health-related organizations to bolster their privacy practices as of April 14, 2003. We are pleased to provide this information to our patients
and to comply with the privacy regulations of the federal Health Insurance Portability and Accountability Act (HIPAA).

Notice of Privacy Practices. Please initial below.

1. I understand that clients may be seen by a licensed therapy assistant and/or one of our clinical students under the direct supervision of a licensed therapist.
2. To comply with HIPAA rules and regulations, please understand that Beyond Boundaries staff is not encouraged to communicate through personal Facebook and/or other personal social media with clients.
3. Beyond Boundaries may:
   a. Call my cell, home or other alternative location and leave a message on voicemail about client's therapy care.
   b. Mail to my home or other alternative location any items that assist in carrying out therapy care such as patient statements.
   c. Email to my home or other alternative location any items that assist in carrying out therapy care such as therapy updates, home programs, progress reports and appointment reminders.
   d. Leave a communication card (handwritten note with session update) in client's personal cubby area at site outside of Beyond Boundaries (ie daycare, school).
4. I have been informed that a picture is required for the medical chart. Photos and videos will be used if necessary for treatment purposes only. Consent for additional use of photo/video will be obtained prior to sharing outside of Beyond Boundaries Therapy.
5. I understand and agree that there may be instances in which the primary therapist may be unavailable (illness, family emergency, etc.). Our policy is to schedule another qualified therapist with the client to carry out the current plan of care for that scheduled session.
6. I acknowledge and agree to the open treatment areas used by Beyond Boundaries Therapy and understand that a private treatment area may not always be available.
7. I agree and understand that other patients will be completing treatment during my visit and may overhear information regarding client's plan of care.

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of Beyond Boundaries Therapy Notice of Privacy Practices. I further acknowledge that this notice as well as any amended Notice of Privacy Practices will be posted at Beyond Boundaries Therapy. I understand that Beyond Boundaries Therapy Services will keep medical records for 5 years from the start of care. By signing this form, I am consenting to allow Beyond Boundaries Therapy to use and disclose client's personal health information to carry out therapy treatment plan of care. I understand that I may revoke my consent in writing except to the extent that the practice has already made
disclosures in reliance upon my prior consent.

_____
Print Name

_____
Signature

_____
Relationship to Patient

_____
Date

OFFICE USE ONLY

Beyond Boundaries Therapy attempted to obtain written agreement for HIPAA Disclosure Form / Patient Consent, but acknowledgement couldn't be obtained because:

☐ Individual refused to sign
☐ Communication barrier prohibited obtaining signature
☐ Emergency prohibited obtaining signature
☐ Other (please specify) _____

_____ _____
Authorized Beyond Boundaries Signature Date

BEYOND BOUNDARIES
THERAPY SERVICES
3001 11th St. So., Fargo, ND 58103
Phone: (701) 356-0062 Fax: (701) 356-5412

Authorization to Disclose/Exchange Protected Health Information

Release of Information (ROI)

CLIENT'S NAME: _____ DATE OF BIRTH:_____

Communication with the primary doctor is required for treatment planning and care.

PRIMARY DOCTOR: _____at _____
Facility

In addition to the Primary Care Provider listed above, I authorize the following to disclose information to and exchange information with Beyond Boundaries Occupational Therapy, Inc. (Occupational Therapy & Physical Therapy) and Beyond Boundaries Speech Language Therapy, Inc.

Below, please indicate entities authorized to disclose/exchange protected health information:

☐ Essentia Health
☐ Sanford Health
☐ Other Medical Facility / Clinic
Name: _____
☐ Southeast Human Service Center
☐ Cass/Clay County Social Services
☐ NDSU – Hippotherapy Program
☐ Psychology / Neuropsychology Name: _____
☐ Community Agencies… ***please specify*** ☐ Fraser ☐ Friendship ☐ RR Human Services ☐ CLS ☐ MCRS
Other _____
☐ Respite Agency ***Name of Agency***: _____
☐ School ***Name of School***: _____
☐ Early Intervention Program…***please specify*** ☐ Anne Carlsen Center ☐ Early Intervention Partners
☐ Daycare ***Name of Daycare***: _____

If information can be shared with other (parent or legal guardian), please indicate name and relationship below:

☐ Other Name: _____ Relationship: _____

Check if you wish to have therapist(s) share session information with any of the following (check ALL that apply):

☐ Grandparents ☐ Nanny/Babysitter ☐ Older Siblings ☐ Other _____

I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation is not valid if (1) action was previously taken in reliance on this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage. I authorize the facility/provider to disclose medical information to the party identified above. I understand that mental health, alcohol/drug use, and HIV treatment records would not be disclosed without further written consent. I understand that once disclosed, information may be re-disclosed by the recipient and is no longer protected. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment or my eligibility for benefits. **This authorization expires one year from the date of my signature unless I specify a different event, purpose or alternative expiration date here:**_____.

Signature: _____ Date: _____ Time: _____

Relationship of Person Signing (if not patient): _____

Client Name:_____ Date of Birth: _____

BEYOND BOUNDARIES PAYMENT POLICIES

Careful, individualized planning and preparation goes into preparing your child for therapy services. At Beyond Boundaries Occupational Therapy, Inc (occupational therapy and physical therapy) and Beyond Boundaries Speech Language Therapy, Inc., we strive to maximize your child's potential and progress with consistent therapy sessions. Consistent attendance is essential to achieving your child's goals and receiving the full benefit of therapy. We want to provide the best experience for you and your child. Please read through our policies on attendance/billing. Our office staff can provide additional information/clarification as needed.

Cancellations & No-Shows (preparation time, 30-45 minutes blocked therapy time, documentation time)

- All cancellations or reschedules must be done by calling the front desk at 701-356-0062.
- Insurance cannot be billed for cancelled or missed therapy sessions.
- Cancellation: If it is necessary to cancel a therapy session, you must provide 4-hour advanced notice or a charge of $50 per missed therapy session will be billed *(EXCEPTIONS: unexpected illness, family emergency, and inclement weather*). If illness affects the client's treatment plan a physician's note will be required. This fee will be charged on your statement. ***If you reschedule this appointment within 5 business days, there will be no charge.***
- No-Show: If a client does not attend a scheduled therapy session a fee of $50 per therapy session will be charged (this includes schools, daycares, and home visits). More than 3 no-shows per therapy could result in discharge from that service.

Billing

- Billing statements will be mailed monthly and payment is due within 30 days. We accept cash, check, HSA cards or major credit cards.
- Overdue balances may result in services being put on hold and/or collections notification.
- Payment plans/financial assistance plans can be arranged with the office manager at any time.
- If your insurance changes, you are required to notify the office in advance or you will be billed for services not covered by your new insurance.

Meeting/Consult Fee

If a parent or outside entity requests a therapist to be present at a meeting outside of Beyond Boundaries or to provide consultative services, a $75 per hour fee will be charged. This fee helps to cover preparation, drive time and meeting time. If a progress note and 15-minute phone call would suffice, there will be no charge for the 15-minute phone call.

Printed Name: _____

_____ _____

Client or Parent/Legal Guardian Signature Date