Arbor Therapy
Speech Therapy | Feeding Therapy | Occupational Therapy | Physical Therapy
Phone: (480) 935-0614 | www.arbortherapies.com | Fax: (480) 393-1968
Locations based in Chandler and Glendale

Please return this completed form with a copy of your ID, the front & back of all insurance cards and any pertinent paperwork (IEP, ISP, BIP, 504) within 48 hours.

DDD - ADULT DEMOGRAPHIC PAPERWORK

Client's Name: _____
First Middle Last

Date of Birth: _____ Sex: ☐ Male ☐ Female ☐ Other

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Email Address: _____

May we leave a message? ☐ Yes ☐ No May we email? ☐ Yes ☐ No

Are you self-sufficient? ☐ Yes ☐ No (If no, please provide Caregiver information)

If applicable, Caregiver Name: _____
First Last

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Email address: _____

If applicable, legal Guardian Name: _____
First Last

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Email: _____

May we leave a message? ☐ Yes ☐ No May we email? ☐ Yes ☐ No

Emergency Contact: _____ Relationship: _____
First Last

Phone: _____

How did you hear about us?

☐ Physician Referral ☐ Community Event ☐ Facebook ☐ Google Search
☐ DDD ☐ Employee Referral ☐ Instagram ☐ Other: _____
☐ School ☐ Client Referral ☐ TikTok

If employee or client referral, please tell us who so we can thank them! Name: _____

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Do you attend a day or treatment facility (Group home or DTA)? ☐ Group home ☐ DTA ☐ N/A

If yes, Name of Facility: _____

Days/Hours of Attendance: _____ Transportation Method: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Facility Contact: _____

PHYSICIAN AND INSURANCE

Primary Care Physician: _____

Address: _____

Phone: _____ Fax: _____

DDD Support Coordinator: _____

SC Phone: _____ SC Email: _____

Primary Insurance Company: _____

Policy #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____

Relationship to Client: _____ SS: _____

Employer: _____

Secondary Insurance Company: _____

Policy #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____

Relationship to Client: _____ SS: _____

Employer: _____

Person Completing Form: _____ **Relationship:** _____
Print

Signature: _____ **Date:** _____

My signature on a facsimile copy, scanned copy, pdf file, or other reproduction of this document shall be as valid and binding as a signed original.

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Medical Information Release

I hereby authorize the release and transfer of any relevant information, including the diagnosis, records of any treatments or examinations rendered, to the client's insurance company or companies, third party payers, current DDD Support Coordinator team, or other health care agencies. A photocopy of this assignment is considered as valid as the original. I also authorize the release of medical records or copies of such and request that they be transferred to Arbor Therapy.

Client/Guardian Signature: _____ Date: _____

Assignment of Benefits

I request that payment of authorized insurance benefits be made on my/the client's behalf to Arbor Therapy.

Client/Guardian Signature: _____ Date: _____

Consent for Care

I hereby agree and give consent for Arbor Therapy to furnish medical care and treatment considered necessary and proper in evaluating and treating the above client's physical condition.

Client/Guardian Signature: _____ Date: _____

Augmentative and Alternative Communication (AAC) Devices

By signing below, I agree that if the client is recommended for or requires the use of an Augmentative and Alternative Communication (AAC) Device, it is my responsibility to ensure this device is present and provided for all scheduled services at Arbor Therapy. I am aware that the client's Support Coordinator will be notified in the event of continual or inconsistent neglect to this policy.

Client/Guardian Signature: _____ Date: _____

Person Completing Form: _____ **Relationship:** _____
Print

Signature: _____ **Date:** _____

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GENERAL AND PREVIOUS TREATMENT

Has the client been previously treated for Speech, Feeding, Occupational, Music and/or Physical therapy?

☐ Yes ☐ No - If yes, please indicate type of therapy, reason for treatment, clinic name, approximate date seen and therapist's conclusion and/or suggestions:

What are your goals for therapy?

Has the client seen any other specialist (i.e., audiologist, psychologist, neurologist, etc.)?

☐ Yes ☐ No - If yes, please indicate type of specialist, approximate date seen, specialist's conclusion and/or suggestions:

Is there a family history of learning disabilities, developmental difficulties, speech/language, hearing problems or physical disabilities in client's family?

☐ Yes ☐ No - If yes, please describe:

What do you think may have caused the problem for the client to need therapy services?

Has the problem changed since it was first noticed?

☐ Yes ☐ No - If yes, how?

Please provide any additional information that might be helpful for treatment:

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GENERAL INFORMATION

Who lives in the home? _____

What Language(s) do you speak? _____

Communication skills (Check as applicable):

☐ Uses complex sentences ☐ Uses simple sentences ☐ Signs ☐ Nods (yes/no) ☐ Gestures

Describe AAC Device (if applicable): _____

Mobility:

Balance while standing:

☐ Excellent/No concern ☐ Moderate (ie. Stumbles) ☐ Poor (ie. Very unsteady, falls)

Utilizes adaptive aids for balance: ☐ Yes ☐ No

Independent Mobility (Check as applicable):

☐ Crawling/Scooting ☐ Kneeling ☐ Standing ☐ Walking ☐ Running ☐ Climbing

Mobility/Balance Aids (Check as applicable):

☐ N/A ☐ Walker ☐ Cane ☐ AFOs ☐ Leg Braces ☐ Wheelchair ☐ Running ☐ Climbing

☐ Other (Specify): _____

Personal Care skills (check all applicable items):

	Eating	Dressing	Toileting	Bathing	Dental Care	Menses	Other
Independent	○	○	○	○	○	○	○
Requires Reminding/ Prompting	○	○	○	○	○	○	○
Requires Limited Assistance	○	○	○	○	○	○	○
Requires Significant Assistance	○	○	○	○	○	○	○

Behavioral Concerns (if applicable):

Brief Description	Approximate Frequency	Recommended Intervention
Aggression		
Self-Injurious Behavior		
Property Destruction		
AWOL		
Self-Stimulation		
Sexual Acting Out		
Other		

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MEDICAL HISTORY

List previous and current long-term medications prescribed:

Food allergies:

Drug allergies:

Has the client had any of the following? If yes, describe and provide approximate dates.

Childhood diseases or major illnesses: _____

Congenital abnormalities: _____

Ear infections: _____

Tubes in ears: _____

Seizures: _____

Hospitalizations: _____

Major surgeries: _____

Assistive Devices:

Vision: _____ **Hearing:** _____ **Dental Appliances:** _____

Protective Devices:

Purpose: _____

Instructions for use: _____

Other Individual Health Care Routines: _____

Please explain any other concerns you may have:

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ATTENDANCE POLICY

Arbor Therapy prides itself on providing the highest quality therapeutic services to our clients and their families. Our attendance policy has been established to respect our therapists' time and efforts providing individualized care and ensure each client is properly adhering to their therapeutic recommendations to the best of their abilities. Poor attendance patterns negatively impact the client's progression, our business, our therapists' time and resources, as well as preventing another client from our wait list awaiting treatment.

Late Policy

- All sessions begin at the scheduled appointment time. If the client arrives late for the session, the appointment will still finish at the scheduled time.
- Arrival more than 15 minutes late will result in a no show.

Cancellation Policy

- Cancellations require 24-hours' notice to the office.
- We understand that life happens and last-minute cancellations may occur for several reasons. You are still responsible for notifying the office with as much notice as possible.

No-Show Policy

- No-Shows include: Arriving more than 15-minutes late to the scheduled session, canceling an appointment less than 24-hours' before the scheduled start time, and no-call/no-shows.
- A $50.00 fee will be charged for any appointment considered a no-show. See “No Show Fee” Policy.

Reschedule Policy

- If you need to cancel your session, you are encouraged to coordinate and complete a make-up session as consistent adherence to therapeutic recommendations is crucial to continue making progress.
- Any make-up session resulting in a No-Show may result in immediate discontinuation of services.
- Clients are limited to four (4) rescheduled appointments per service per quarter.

Attendance Policy

- Clients with more than three (3) cancellations or two (2) no-shows in a quarter are at risk of being removed from their appointment time slot, moved to a flex schedule, or discontinued from care. The quarters are as follows: **January-March / April-June / July-September / October-December**
- If placed on a flex schedule, it is the client's responsibility to call Arbor Therapy and schedule appointments on a week-to-week basis.
- Email reminders are sent the day before a scheduled appointment, as a courtesy. Maintaining consistent attendance is your responsibility and not dependent upon the receipt of an email reminder.
- Our office reserves the right to release clients for any reason that causes undue interruption to services.
- **Parent/guardians or caregivers are not to leave the premises during a session. Violation of this policy will result in immediate discharge from all services.**

By signing below, I acknowledge that I read, understand, and agree to follow Arbor Therapy’s attendance policy. Additionally, I acknowledge that this policy is subject to change.

Client Name - PRINTED	Date
Client/Guardian Signature	Relationship

My signature on a facsimile copy, scanned copy, .pdf file, or other reproduction of this document shall be valid and binding as a signed original.

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NO SHOW FEE POLICY

Arbor Therapy prides itself on providing the highest quality services to our clients and their families. For the best therapeutic value for our clients, consistent attendance is required to maximize progress. Out of respect for our therapists' time and to ensure another client who needs services can be contacted and seen, we require 24-hour notice of any cancellation request. We understand that unforeseen situations or emergencies may arise. Please note: it is your responsibility for notifying the office with as much notice as possible.

A fee of $50.00 will be charged for any no showed appointments and/or cancellations made within 24 hours of their scheduled times. This includes ongoing sessions, make-up sessions, and evaluations.

If you no show or cancel your appointment within 24-hours of its schedule time:

- The $50.00 amount due will be charged to the card on file at the time of cancellation or no-show

If the No Show Fee is not collected:

- The charge is due prior to the beginning of your next scheduled appointment
- If the fee is not collected prior to your next scheduled appointment, you will not be seen
- If the fee is not collected prior to your next scheduled appointment you will be removed from your ongoing schedule and added to our holds list. You will remain here until the fee is paid or 3-months time, whichever comes first. Note: Once removed from your ongoing schedule, we cannot guarantee or reserve your schedule

This policy is in accordance with our current attendance policy and is in place out of respect for our therapists and clients. If you need to cancel or reschedule an appointment, we ask that you notify our offices a minimum of 24 hours in advance.

*** This policy applies to all Non-AHCCCS clients only.

Our office reserves the right to release clients for any reason that causes an undue interruption of services. Parent/guardians and caretakers are not to leave the premises during a session. Violation of this policy will result in discharge from Arbor Therapy.

By signing below, I acknowledge that I read, understand, and agree to follow Arbor Therapy's attendance policy. Additionally, I acknowledge that this policy is subject to change.

Client Name - PRINTED	Date
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DISCLOSURE OF HEALTH INFORMATION

Client's Name: _____ DOB: _____

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct the client's health care provider, Arbor Therapy, to disclose or transfer health information during the term of this authorization to the recipient(s) (outside of the pertinent agencies noted in the Medical Information Release) I have identified below:

Recipient: Name of person or class of persons to whom the client's health care provider may disclose health information either in writing or verbally:

Name	Phone	Fax# or Email
_____	_____	_____
_____	_____	_____
_____	_____	_____

Redisclosure: I understand that once Arbor Therapy discloses client's health information to the recipient identified above, Arbor Therapy cannot guarantee that the recipient will not redisclose health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that the client may refuse to sign or may revoke (at any time) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of the clients treatment by Arbor Therapy.

Revocation: I understand that this authorization will remain in effect until the term of this authorization expiration, or I provide a written notice of revocation to Arbor Therapy where treatment is received. The revocation will be effective immediately upon Arbor Therapy's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this authorization before it received my written notice of revocation.

Client/Guardian Signature: _____ Date: _____

NOTICE AND ACKNOWLEGEMENT OF PRIVACY PRACTICES

Arbor Therapy reserves the right to change our privacy practices and terms of this notice at any time as permissible by law. In case of changes to privacy practices or terms in this notice, a new notice will be available upon request. You can request a copy of our Notice of Privacy Practices at any time. For more information about our privacy practices, or for additional copies of this Notice, please call Arbor Therapy at (480) 935-0614.

1. Privacy Practices related to therapy sessions:

It is our intention and priority to honor and maintain client's confidentiality. Arbor Therapy will discuss therapy session with the client and/or guardian at the end of the appointment. If you prefer a private, confidential communication about the client's therapy session, please notify therapist before the session. All information discussed will be kept confidential, except, in instances related to suicidal/homicidal ideation and/or allegations of abuse/neglect.

2. Uses and disclosures of Health Information:

Arbor Therapy may use and disclose health information for treatment, payment, and healthcare operations. Examples:

A. **Treatment:** Arbor Therapy may use and disclose health information with your signed consent to a physician or other health care provider providing treatment to the client.
B. **Payment:** Arbor Therapy may use and disclose health information with your signed consent to obtain payment for services we provide the client.
C. **Healthcare Operations:** Arbor Therapy may use and disclose health information in connection with internal healthcare operations, including quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, certification, licensing, or credentialing services.
D. **Marketing Health-Related Services:** Arbor Therapy will not use client's health information for marketing communications without your written authorization.
E. **Required by Law:** Arbor Therapy may use or disclose the client's health information when required by law to do so.
F. **Abuse or Neglect:** Arbor Therapy may disclose client's health information to appropriate authorities if we have reason to believe the client is a possible victim of abuse, neglect, and/or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to the client's safety or the health and safety of others.
G. **Appointment Reminders:** Arbor Therapy may use or disclose health information to provide you with appointment reminders (such as voicemail or e-mail messages, postcards, or letters).
H. **Integrated Care:** To maximize the clinical outcomes for our clients, Arbor Therapy has implemented an integrated care model under Arbor Therapy. Under the integrated care model, Arbor Therapy will share records with contracted providers via HIPAA compliant electronic records software. All contracted providers have entered into a contractual Business Associate Agreement, which requires HIPAA compliance and ensures that all information will be accessed

on a need-to-know basis. This approach ensures that doctors, therapists, and behavioral health professionals maintain consistent communication and access to records as relevant to the treatment of our clients.

By signing below, I acknowledge I have received, read, and understand Arbor Therapy's Notice of Privacy Practices.

Client/Guardian Signature: _____ Date: _____

Pre-Service Orientation Acknowledgement

By signing below, I acknowledge that the above information has been completed to the best of my ability and acts as a pre-service orientation prior to receiving services at Arbor Therapy. I understand the above information will be reviewed by provider(s) prior to receiving services.

Client/Guardian Signature: **_____ Date: _____**