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.

ADULT DEMOGRAPHIC PAPERWORK

Client's Name: _____
First Middle Last

Date of Birth: _____ ☐ 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, tell us who so we can thank them! Name: _____

Does the client attend a day 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: _____

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: _____

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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.

Signature: _____ Date: _____

Assignment of Benefits

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

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.

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.

Signature: _____ Date: _____

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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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 simply 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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FINANCIAL POLICY

Arbor Therapy does everything possible to minimize the cost of medical care. Clients can help a great deal by eliminating the need for Arbor to bill. The following is summary of our payment policy:

All payment is expected at the time of service.

Payment is required at the time services are rendered. We have a contractual obligation (with your insurance company) to collect all co-pays and co-insurance. This includes applicable co-payments for participating insurance companies. Payment will be collected when you check in. We are unable to bill co pays/coinsurance to you. Patients are required to keep a credit card on file with the front office. This credit card will be charged on the date of service for all payments due.

Insurance

All insurance cards *must* be provided with intake form and in order to schedule services. It is the patient's responsibility to update insurance information, current address and contact information, within 24 hours of the change, for our records. Failure to do so will cause the patient to become responsible for all charges. Arbor Therapy will bill participating insurance companies as a courtesy to our clients. Clients are expected to pay their deductibles and co-payments at the time of service. If we have not received payment from your insurance company, the client will be expected to pay the balance in full. Clients are responsible for all charges. If your insurance company requires you to have a referral or authorization for services, please verify with our front office that a current referral or authorization is on file. Our office will put forth as much effort as possible to help obtain these documents, however, the client is ultimately responsible for any resulting costs that may be associated with your visits. Clients accept all financial responsibility in the event of non-covered services. Clients accept all financial responsibility if they choose to be seen prior to verification of benefits or prior authorization obtained.

Forms of Payment Accepted

Arbor Therapy accepts Cash, Visa, Mastercard, Discover and American Express. Please note, we DO NOT accept personal checks.

Outstanding Balance

Once payment is received from your insurance company, you will be billed for any remaining amount and the credit card on file will be charged as indicated. Payment for outstanding balances is expected within 10 business days. Client with an outstanding, overdue balance of 30 days must make payment arrangements prior to scheduling future appointments. If your account becomes delinquent by more than 60 days, we will be forced to forward it to a collection agency. If your account is sent to an outside collection agency, we will add a collection fee to your account balance. The collection fee charged will be equal to the amount that the collection agency charges Arbor Therapy. You will be responsible for paying the full balance, including this

fee. We realize that some clients may have financial difficulty. Please communicate with our billing department, so they may assist in creating a financial plan with you, prior to getting collections involved.

Refunds

Overpayments will be refunded upon written request to the responsible party within 30 days of our office confirmation. Otherwise, overpayments will be applied as a credit to your account.

Financial Policy

I agree to the terms of the payment and cancellation policy and request that payment of authorized insurance benefits be made on my behalf to Arbor Therapy. I understand and agree that I am ultimately responsible and liable for payment of all charges assessed for professional services rendered by Arbor Therapy and will pay any sum due upon demand. I understand that insurance claim forms will be submitted to my insurance company as a matter of convenience. I understand and agree that if it becomes necessary to retain an attorney and/or collection agency for the collection of any outstanding charges, whether or not a lawsuit is filed on my account, I will be responsible for any attorney and/or collection fees and court costs in addition to the outstanding balance.

I hereby authorize my insurance benefits to be paid directly to Arbor Therapy, realizing I am responsible to pay all non-covered services. If proper & current insurance information is not given, I will be responsible for all charges. I hereby authorize the release of pertinent medical information to insurance carriers. I understand if this account should become delinquent & referred to a collection agency, I will be responsible for any collections or legal fees.

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

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ADVANCED BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

Client's Name: _____ DOB: _____

If the insurance company does not pay for services described below, client may be responsible to pay for all or a partial portion of services provided.

Services:

- Speech Therapy
- Feeding Therapy
- Occupational Therapy
- Physical Therapy
- Music Therapy

What you need to do:

- Read this notice so you can make an informed decision about your care.
- Ask Arbor Therapy any questions you may have after reading before you sign.
- Sign document only if you wish to have the services listed above.

Check only one box to indicate your decision:

☐ I would like to pursue Arbor Therapy for at least one (1) of the services listed above and understand that I may be required to pay for service now but would like my insurance carrier(s) billed. If payment is made for service(s) listed, I will receive a refund, less any applicable copays or deductibles.

☐ I would like to pursue Arbor Therapy for at least one (1) of the services listed above but I do not want my insurance billed. I understand that there will be no appeal rights with my insurance carrier if they are not billed.

My signature below confirms that I have read and understand this Advanced Beneficiary Notice of Noncoverage (ABN):

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

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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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BANK CARD AUTHORIZATION FORM

Please note that if the client receiving services from Arbor Therapy has AHCCCS/Medicaid, a bank card is still required to have on file. However, **you will not be charged**, as long as, the client receiving services maintains AHCCCS/Medicaid coverage.

Client's Name: _____ DOB: _____

Bank Card Holder Name/Address:

Cardholder's Name (As it appears on card): _____

Street: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Credit Card number: _____

Expiration date: _____ Security Code: _____

☐ Please automatically run this credit card for any outstanding balances after EOB's are reconciled.

☐ Please call or email me before running this credit card for any outstanding balances after EOB's have been reconciled.

As the credit card holder, I, hereby authorize Arbor Therapy, to charge my card for the amount(s) of co-pay and/or invoice/payment(s) due. I understand that my information will be saved to file for future transactions for this account. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement.

_____ _____
Cardholder's Signature **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: _____

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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 is 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 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 for consult, 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 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, domestic violence and/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 appointment reminders (such as voicemail or e-mail messages, postcards, or letters).
H. **Integrated Care:** To maximize clinical outcomes for our clients, Arbor Therapy has implemented an integrated care model. Under this model, Arbor Therapy may 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 all treating professionals maintain consistent communication and access to records as relevant to the treatment of our clients.

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

Client/Guardian 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.