Arbor Therapy
Speech Therapy | Feeding Therapy | Occupational Therapy | Physical Therapy
Ph: (480) 935-0614 | Fax: (480) 393-1968 | www.arbortherapies.com

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).

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 below

If applicable, Caregiver Name: _____
First Last

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Email Address: _____

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

If applicable, Legal Guardian Name: _____
First Last

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Email Address: _____

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

Emergency Contact: _____ Relationship: _____
First Last

Primary Phone: _____

How did you hear about us?

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

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

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

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PHYSICIAN AND INSURANCE

Primary Care Physician Practice/Office: _____

Primary Care Physician's Name: _____

Address: _____

Phone: _____ Fax: _____

Primary Insurance Company: _____

Policy #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____

Relationship to Client: _____ SSN: _____

Employer: _____

Secondary Insurance Company: _____

Policy #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____

Relationship to Client: _____ SSN: _____

Employer: _____

Tertiary Insurance Company: _____

Policy #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____

Relationship to Client: _____ SSN: _____

Employer: _____

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PRESENTING CONCERNS AND PREVIOUS TREATMENT

Describe your current concerns and the reason you are seeking treatment:

When did these concerns first arise?

Were there any significant life events around the time the concerns arose? (e.g. Major illness, injury, move, etc.)
☐ Yes ☐ No – If yes, please describe:

What are your goals for therapy?

Has the cliemt been previously treated for Speech, Feeding, Occupational, and/or Physical Therapy?
☐ Yes ☐ No – If yes, please indicate the type of treatment, reason for treatment, clinic name, approximate date seen and therapist's conclusions and/or suggestions:

Has the client seen any other specialist (e.g. Audiologist, Psychologist, Neurologist, etc.)?
☐ Yes ☐ No – If yes, please indicate the type of specialist, approximate date seen, specialist's conclusions and/or suggestions:

If there a family history of learning disabilities, developmental delays, speech/language, hearing problems or physical disabilities? ☐ Yes ☐ No – If yes, please describe:

Please provide additional information that might be helpful for treatment:

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FAMILY AND HOME INFORMATION

Please list all people, including relatives and non-relatives, that live in the home with the client:

Name	Age	Sex	Relationship to Client
		M F	
		M F	
		M F	
		M F	
		M F	
		M F	

EMPLOYMENT/DAY PROGRAM

Complete the following if the client currently participates in an Employment or Day Program.

Name of Employment/Day Program: _____

Program Type: _____ Program Location (City): _____

Days/Hours of Attendance: _____

SOCIAL AND ACADEMIC

What is the highest level of education completed by the client?

- ☐ Some High School
- ☐ High School Diploma
- ☐ High School GED
- ☐ Some College
- ☐ College Degree

Did the client have an IEP or 504 Plan while attending school to support them in a learning environment?

☐ Yes ☐ No

Does the client appear to enjoy engaging with others? ☐ Yes ☐ No

Describe the client's preferred hobbies and interests:

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MEDICAL HISTORY

It is very important to have as complete a medical history for the client as possible. Please fill out the grid below, making sure you include an explanation for any questions answered "yes." In your explanation, please include the client's age(s) if relevant, any diagnoses made, and any treatments that have occurred.

		Description	Explanation
Yes	No	Frequent Colds/Respiratory Illness	
Yes	No	Frequent Strep Throat/Sore Throat	
Yes	No	Frequent Ear Infection/PE Tubes	
Yes	No	Lung Conditions/Respiratory Disorder	
Yes	No	Asthma	
Yes	No	Heart Condition	
Yes	No	Anemia/Blood Disorder	
Yes	No	Renal Disorder/Urinary Problems	
Yes	No	Muscle Disorder/Muscle Problems	
Yes	No	Join or Bone Problems/Fractures	
Yes	No	Skin Disorder/Skin Problems	
Yes	No	Visual Disorder/Visual Problems	
Yes	No	Eye Infections	
Yes	No	Neurological Disorders/Seizures	
Yes	No	Stomach Disorders/Stomach Pain	
Yes	No	Vomiting/Digestion Problems	
Yes	No	Failure to Gain Weight	
Yes	No	Constipation/Diarrhea Problems	
Yes	No	Dehydration Episodes	
Yes	No	Hearing Loss/Ear Disorder	
Yes	No	Tongue-Tie or Cleft Palate	
Yes	No	Significant Accident/Injury	
Yes	No	Head Injuries/Concussions	
Yes	No	Ingestion of Toxins, Poisons, or Foreign Objects	
Yes	No	Major Childhood Illness (pox, croup, measles, etc.)	

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Please list the dates of any hospitalizations the client has had and the reason. List the dates of any surgeries the client has had and the reason.

1. _____
   _____
2. _____
   _____
3. _____
   _____

Has the client ever been diagnosed with any of the following? Check all that apply.

- ☐ ADHD/ADD
- ☐ Anxiety Disorder/Mood Disorder (Specify: _____)
- ☐ Autism Spectrum Disorder
- ☐ Cognitive Delay
- ☐ Down Syndrome
- ☐ Dyslexia
- ☐ Emotional Disorder (Specify: _____)
- ☐ Fragile X Syndrome
- ☐ Learning Disability (Specify: _____)
- ☐ Sensory Processing Disorder/Sensory Integration Dysfunction
- ☐ Other (Specify: _____)

For any diagnoses marked above, please list the name of the doctor who provided the diagnosis and year of diagnosis:

_____

_____

List any medications the client is currently taking:

Medication: _____ Purpose: _____ Dosage/Frequency: _____
Medication: _____ Purpose: _____ Dosage/Frequency: _____
Medication: _____ Purpose: _____ Dosage/Frequency: _____
Medication: _____ Purpose: _____ Dosage/Frequency: _____

The client has the following allergies: (Check all that apply.)

- ☐ Food
- ☐ Medication
- ☐ Bee stings
- ☐ Other

If any allergies were checked, please explain: _____

_____

What is the required response to an allergic reaction? Please provide any written orders for Arbor Therapy.

_____

_____

Does the client experience seizures? ☐ Yes ☐ No

If yes, please provide what type of seizures, what they look like, approximate frequency and duration:

_____

_____

What is the required response to seizure activity? Please provide any written orders for Arbor Therapy.

_____

_____

Assistive Devices:

Vision: _____ Hearing: _____ Dental: _____

Protective Devices:

Purpose: _____

Instructions for use: _____

Other Individual Health Care Routines: _____

COMMUNICATION

What languages is the client exposed to? _____

If the client uses spoken words, what languages does the client speak? _____

What is the client's preferred/primary language? _____

How does the client communicate? Check all that apply.

- ☐ Facial expressions (e.g. grimacing, smiling)
- ☐ Actions/Gestures (e.g. pointing, pulling your hand, giving you an object)
- ☐ Sounds or vocalizations (e.g. babbling, cooing)
- ☐ Single spoken words
- ☐ Spoken phrases
- ☐ Spoken sentences
- ☐ Pictures (If the client has an AAC device, please list the make/model: _____)
- ☐ Manual signs (e.g. ASL)

Are any of the following a concern for the client? Circle all that apply.

Yes	No	Expresses frustration when trying to communicate
Yes	No	Has difficulty pronouncing certain words
Yes	No	Has difficulty answering questions
Yes	No	Has difficulty understanding basic concepts and safety words (Yes/No, Stop/Go, etc.)
Yes	No	Struggles to convey clear message when speaking, even if words are easy to say
Yes	No	Gets stuck on or repeats words when talking
Yes	No	Has difficulty with his/her voice, vocal quality, or breathing
Yes	No	Has a hard time making friends
Yes	No	Has difficulty understanding and following social rules

MOBILITY

What is the client able to do independently? Circle all that apply.

Yes	No	Crawl/Scoot	Yes	No	Hop (Two feet)
Yes	No	Kneel	Yes	No	Hop (One foot)
Yes	No	Stand	Yes	No	Jump down from curb
Yes	No	Walk	Yes	No	Climb up stairs
Yes	No	Run	Yes	No	Climb down stairs
Yes	No	Climb			

How would you describe the client's balance?

- ☐ Excellent
- ☐ Moderate (e.g. some stumbling or need or occasional support)
- ☐ Poor (e.g. very unsteady or needs frequent support)

Does the client use any mobility or balance aids? Circle all that apply.

Walker Cane AFOs Leg braces Wheelchair

Other (Specify: _____)

BEHAVIOR

Description	Approximate Frequency	Describe behavior and current management strategies:
Aggression towards others		
Self-injurious behavior		
Property destruction		
Elopement		
Self-stimulation		
Sexual acting out		
Ingesting inedible objects		
Difficulty with transitions		
Crisis Intervention/Hospitalization within last 6 months		
Difficulty understanding consequences		
Substance abuse (Drug, alcohol, other)		
Other		

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PERSONAL CARE AND FEEDING

Mark the client's level of independence for the following actions:

	Independent	Needs Reminding or Prompting	Needs Some Help	Needs Maximum Support
Dressing	◯	◯	◯	◯
Toileting	◯	◯	◯	◯
Bathing	◯	◯	◯	◯
Dental Care	◯	◯	◯	◯
Menses, *if applicable*	◯	◯	◯	◯
Uses utensils to feed self	◯	◯	◯	◯
Drink from open cup	◯	◯	◯	◯
Drink from straw	◯	◯	◯	◯
Take small bite of larger piece of food	◯	◯	◯	◯
Recognize/Understand temperatures of food/drink	◯	◯	◯	◯
Accepts variety of age-appropriate textures and food/drink types	◯	◯	◯	◯

Does the client ever cough or choke while eating or drinking? ☐ Yes ☐ No – If yes, please describe:

Describe any special dietary requirements (e.g. food consistency/temperatures, feeding tube, caloric needs, etc.):

Please explain any other concern you may have:

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.

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, 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.

Assignment of Benefits

I request that payment and authorized insurance benefits be made on the client's behalf to Arbor Therapy. I recognize and understand that Arbor Therapy will submit claims on my behalf for services rendered at Arbor Therapy and will receive payments from my insurance carrier(s) directly for services rendered. I understand that outstanding payments for services rendered at Arbor Therapy may be my responsibility should my insurance carrier(s) not provide payment.

Student Observers and Educational Placement Notice

Arbor Therapy hosts students enrolled in accredited programs for observations and clinical placements. I acknowledge that student observers may be present during therapy sessions for educational purposes. I consent to the client receiving therapy services provided by student therapists under the direct supervision of licensed and qualified professionals at Arbor Therapy. I understand that student observers and therapists are bound by strict ethical standards and confidentiality agreements to ensure the safety, wellbeing, and privacy of the client.

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.

_____	_____
Client Name – PRINTED	Relationship
_____	_____
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 end at the scheduled end time.
- Arrival more than 15 minutes late will result in a No-Show and need to be rescheduled.

Cancellation Policy

- Cancellations require 24-hours' notice to the office.
- We understand that life happens, and last-minute cancellations may occur. 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 appointment, 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 the client's responsibility and not dependent on the receipt of an email reminder.
- Our office reserves the right to release clients for any reason that causes undue interruption to services.
- **Parents, guardians, and caregivers are not to leave the premises during a session. Violation of this policy will result in immediate discharge from all services.**

_____	_____
Client Name – PRINTED	Relationship
_____	_____
Client/Guardian – Signature	Date

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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 charge for any appointment resulting in a no-show, including cancellations made within 24-hours of the scheduled start time. This includes ongoing sessions, make-up sessions, and evaluations.

If you no-show or cancel your appointment within 24-hours of its scheduled start time: A $50.00 amount due will be charged to the card on file at the time of the cancellation or no-show.

If the No-Show Fee is not collected:

- The charge will be due prior to the beginning of the next scheduled appointment.
- If the fee is not collected prior to the beginning of the next scheduled appointment, the client will not be seen.
- If the fee is still not collected, the client may be removed from an ongoing appointment time slot and added to our waitlist. The client will remain on the wait list until the fee has been paid or 3-months' time, whichever comes first. Note: Once removed from an ongoing schedule, we cannot guarantee or reserve your existing 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 office a minimum of 24 hours in advance.

Please note, this policy applies to 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.

_____ _____
Client Name – PRINTED Relationship

_____ _____
Client/Guardian – Signature Date

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FINANCIAL POLICY

- **All payment is due at 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. Payment will be collected when you check in. Clients are required to keep a bank (credit/debit/other) card on file with the front office. This 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 client's responsibility to update insurance information, current address and contact information, within 48-hours of any change. Failure to do so may cause the patient to become responsible for all charges and cause a disruption to services. 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 or if the client chooses to be seen prior to obtaining prior authorization.

- **Forms of Payment Accepted –** Arbor Therapy accepts Cash, Visa, Mastercard, Discover, and American Express. 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 bank 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 equivalent to the fee charged to Arbor Therapy. You will be responsible for paying the full balance.

- **Refunds** - Over-payments will be refunded upon written request to the responsible party within 30 days of our office confirmation. Otherwise, over-payments will be applied as a credit to your account.

- **Financial Policy** - I 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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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 the card): _____

Street: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email Address: _____

Bank/Debit/Credit Card number: _____

Expiration date: _____ Security code: _____

☐ Please automatically run this card for any outstanding or current balances.

☐ Please call or email me before running this card for any outstanding or current balances.

As the bank 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.

Client/Guardian 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 Number	Fax # or Email Address
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Redisclosure: I understand that once Arbor Therapy discloses a 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 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 immediate 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 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 sessions with the parent/guardian or caregiver at the end of the appointment. If you prefer a private, confidential communication about the client's therapy session, please notify the 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, such as:

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 that I have received, read, and understand Arbor Therapy's Privacy Practices. 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**: _____

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