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).

PEDIATRIC DEMOGRAPHIC PAPERWORK

Client's Name: _____
First Middle Last

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

Address: _____

City: _____ State: _____ Zip Code: _____

Parent/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

Parent/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.

Does the client attend a day program or treatment facility (Group home or DTT)? ☐ Group home ☐ DTT ☐ 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 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 for your child:

When did these concerns first arise?

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

What are your goals for therapy?

Has the child 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 child 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	

PREGNANCY AND BIRTH HISTORY

Please list all medications (prescriptions and over the counter) taken during pregnancy with the client:

_____

_____

Were there any complications during pregnancy (e.g. anemia, pre-eclampsia, accident/physical injury, infection, preterm labor, confinement to bed, etc.)? ☐ Yes ☐ No – If yes, please describe in detail:

_____

_____

Gestational age at time of delivery (or # of weeks early/late): _____ Length of labor (Hours): _____

Type of delivery: ☐ Vaginal ☐ Voluntary Cesarean Section ☐ Emergency Cesarean Section

Reason for Emergency C-Section, if applicable: _____

Where there any complications *during* the delivery (e.g. maternal infection, low/high blood cell count, placenta problems, cord around baby's neck, baby had low/high heart rate, fetal distress, meconium present, etc.)?
☐ Yes ☐ No – If yes, please describe in detail:

_____

_____

Did the client experience any of the following conditions or difficulties after birth? Circle all that apply.

Yes	No	Blue/Cyanotic at Birth	Yes	No	Very Low Tone
Yes	No	Required Stimulation to Breathe	Yes	No	Congenital Birth Defects
Yes	No	Required Oxygen at Birth	Yes	No	Anemia and/or Blood Transfusions
Yes	No	Required Resuscitation	Yes	No	Jaundice (Yellow)
Yes	No	Considered Small at Gestational Age	Yes	No	Rh Incompatibility Problems
Yes	No	Had Tremors or Seizures	Yes	No	Brain Hemorrhage
Yes	No	Needed Ventilation	Yes	No	Choking or Vomiting Episodes
Yes	No	Aspiration (Meconium or Fluid)	Yes	No	Tube Feedings
Yes	No	Respiratory Distress	Yes	No	Needed Medications

If you circled "Yes" to any of the above, please provide an explanation of each event below:

_____

_____

ADOPTION HISTORY

If the client is not adopted, skip to the next section.

Please describe the circumstances surrounding the adoption: _____

_____

At what age was the child adopted? _____ In what year did the adoption take place? _____

Were there any physical or health concerns for the child at the time of adoption? _____

_____

Was the child previously in a foster home? ☐ Yes ☐ No

What was the child's response to a new home? _____

_____

Has there been positive bonding and engagement between the child and adoptive parents? ☐ Yes ☐ No

Does the child accept physical contact (e.g. cuddling, hugs) from adoptive parents? ☐ Yes ☐ No

Is your child aware of his/her adoption? ☐ Yes ☐ No

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MEDICAL HISTORY

It is very important to have as complete a medical history for your child as possible. Please fill out the grid below, making sure you include an explanation for any questions answered "yes." In your explanation, please include your child'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.)	

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 your child 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 your child is currently taking:

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

The child 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.

_____

_____

DEVELOPMENTAL HISTORY

Indicate the age when your child first did each of the following **independently**. Or, *if you cannot recall/find a specific age*, please mark whether you believe your child accomplished the milestone early, on time, or late. If your child has not yet achieved the milestone, write N/A in the age column.

Age, *if known*	**Skill**	**Early**	**Late**	**On Time**
	Smiled			
	Held head up			
	Rolled over			
	Sat unsupported			
	Crawled			
	Walked by his/her self			
	Said first words			
	Spoke 2 – 3 word phrases			
	Ran by his/her self			
	Drank from open cup			
	Ate using spoon/fork			
	Chewed solid food			
	Toilet trained			

Visual Development:

Has your child experienced any problems with his/her eyesight or vision? _____

_____

When was the last time your child had their eyesight tested and what were the results? _____

_____

Auditory Development:

Has your child experienced any problems with his/her hearing (e.g. operations, infections, tubes placed)?

_____

_____

How often and to what severity has your child had ear infections? Please circle all that apply.

- ☐ Seldom/Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Mild
- ☐ Moderate
- ☐ Severe

When was the last time your child had their hearing checked and what were the results? _____

_____

Sensory and Motor Development: Check all that apply. If yes, please circle the corresponding area(s).

☐ Yes ☐ No My child seems to be overly sensitive to sensory experiences more so than most people. If yes, please select all applicable areas:
Auditory Tactile (Touch) Visual Movement Taste Smell

☐ Yes ☐ No My child does not seem to react to sensory experiences as readily as most people. If yes, please select all applicable areas:
Auditory Tactile (Touch) Visual Movement Taste Smell

☐ Yes ☐ No My child actively seeks out sensory experiences more so than most people. If yes, please select all applicable areas:
Auditory Tactile (Touch) Visual Movement Taste Smell

☐ Yes ☐ No My child has difficulty differentiating sensory experiences (e.g. confuses sounds, can't find objects in drawer without looking, bumps into things). If yes, please describe:

☐ Yes ☐ No My child has trouble learning new movements.

☐ Yes ☐ No My child tends to be clumsy and has balance and coordination problems.

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Do any of the following behaviors describe your child currently or in the past? If yes, please explain.

		Description	Explanation
Yes	No	Thumb sucking/pacifier	_____
Yes	No	Sleeping problems	_____
Yes	No	Colic or "fussy baby"	_____
Yes	No	Ability to self soothe	_____
Yes	No	Disliked laying on stomach	_____
Yes	No	Disliked laying on back	_____
Yes	No	Walked on toes	_____
Yes	No	Excessive drooling	_____
Yes	No	Temper tantrums	_____
Yes	No	Head banging	_____
Yes	No	Breath holding	_____
Yes	No	Bed-wetting	_____
Yes	No	Nightmares	_____
Yes	No	Unusual fears	_____
Yes	No	Major mood swings	_____
Yes	No	Aggression/destructiveness	_____

Assistive Devices:

Vision: _____ Hearing: _____ Dental: _____

Protective Devices:

Purpose: _____

Instructions for use: _____

Other Individual Health Care Routines: _____

SOCIAL AND ACADEMIC

Does your child currently attend school? ☐ Yes ☐ No

If yes, what school and grade? _____

Has your child demonstrated difficulty with reading, math, or writing? ☐ Yes ☐ No

If yes, please describe the challenges and when they were first noticed:

Does your child appear to enjoy engaging with same-aged peers? ☐ Yes ☐ No

Describe your child's preferred types of play (e.g. playing independently, pretend play with peers, active play, etc.):

Does your child have a favorite toy or item that he/she enjoys (e.g. Legos, Thomas the Train, etc.)?

COMMUNICATION

What languages is your child exposed to at home and in school? _____

If your child uses spoken words, what languages does your child speak? _____

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

How does your child communicate with you? 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 your child has an AAC device, please list the make/model: _____)
- ☐ Manual signs (e.g. ASL)

Are any of the following a concern for your child? 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

Is your child able to do the following actions 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 your child's balance?

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

Does your child 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		
Other		

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PERSONAL CARE AND FEEDING

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

	Independent	Needs Reminding/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 your child 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 and consent to my child 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
_____	_____
Parent/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.

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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

_____ _____
Parent/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.

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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

_____ _____
Parent/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.

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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.

Parent/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.

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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.

Parent/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.

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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.

Parent/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.

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

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.

Parent/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.