INFINITE THERAPY SOLUTIONS, LLP
PATIENT INTAKE FORM

Patient Name: _____
Last First Middle

Parent Name: _____
Mother Father

Address: _____
No. & Street City State Zip Code

Phone # Home: _____Work_____ Cell_____

Date of Birth:_____ Sex: M____ F____ Age: _____

Email: _____

EMPLOYERS NAME & ADDRESS: _____

REFERRED BY: _____

PRIMARY CARE DOCTOR: _____

INSURANCE INFORMATION

PRIMARY
Name of Insurance:_____
Name of Subscriber: _____ Date of Birth:_____
ID # _____ Group #_____
Insurance Telephone # _____

MEDICAL HISTORY QUESTIONNAIRE

Therapy Services Requested: PT OT Speech Behavioral
Parent Concerns: _____
Medications: _____
Allergies: _____
Diagnosis:_____ICD-10 _____
Does Your Child Have a Prescription for Therapy Services? Y/ N

School Name: _____ Grade :_____
Does Your Child have an IEP? Y/ N
Does Your Child Receive Therapy at School? _____Frequency: _____
Does/Did Your Child Receive Early Intervention? Y/ N
Circle: PT OT Speech Behavioral

INFINITE THERAPY SOLUTIONS, LLP

AGREEMENT FOR BAYONNE RESIDENTS

Infinite Therapy Solutions, LLP has in no way solicited me from the Bayonne Board of Education. I understand that ITS is a separate entity and not affiliated with BBOED. I am not able to use the recommendations, evaluation, or paperwork related to my child's therapy services produced by ITS in the Bayonne Educational System. The intentions of ITS is ancillary and complimentary to other therapies they are currently receiving.

ITS maintains patient confidentiality and abides by HIPPA regulations. Only with the written consent of the parent, are any employees of ITS able to communicate with other outside professionals in regards to the care of the child.

_____ _____

Parent Signature Date

INFINITE THERAPY SOLUTIONS, LLP

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Under Health Insurance Portability & Accountability Act of 1996 (HIPAA), you have certain right to privacy, which are outlined in the HIPAA form provided. This information will be used to:

1) Plan, conduct and direct your treatment and follow-up among multiple health care providers involved in your treatment.
2) Obtain payment from third party payers.
3) Conduct normal healthcare operations such as quality assessment and physician certification

You have the right to review a NOTICE OF PRIVACY PRACTICES prior to signing this consent. This organization has the right to change its Notice of Privacy Practices from time to time and that you may contact this organization at anytime to obtain a copy of the Notice of Privacy Practices.

You may revoke this consent in writing at anytime.

By signing below, I acknowledge that I have been provided a copy of the information about me may be used and disclosed by [_Infinite Therapy Solutions, LLP__] and how I may obtain access to and control this information.

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date

INFINITE THERAPY SOLUTIONS, LLP

PHOTOGRAPHY CONSENT FORM/RELEASE

I, (print name) _____, hereby grant permission to Infinite Therapy Solutions, LLP representatives, to take and use: photographs and/or digital images of me for use in news releases and/or promotional materials. These materials might include printed or electronic publications, web sites, or other electronic communications. I further agree that my name and identity may be revealed in descriptive text or commentary in connection with the image(s). I authorize the use of these images without compensation to me. All negatives, prints, digital reproductions shall be the property of Rainier Foothills Swim Team representatives.

_____ _____

(Signature of adult subject over age 18) (Date)

Release For Minor Children (Under the age of 18) I, (print name) _____, parent or official guardian of (print child's name) _____, hereby grant permission to Rainier Foothills Swim Team representatives, to take and use: photographs and/or digital images of my child for use in news releases and/or promotional materials. These materials might include printed or electronic publications, web sites, or other electronic communications. I further agree that my child's name and identity may be revealed in descriptive text or commentary in connection with the image(s). I authorize the use of these images without compensation to me. All negatives, prints, digital reproductions shall be the property of Infinite Therapy Solutions, LLP representatives. _____ _____

(Signature of child's guardian over age 18) (Date)

INFINITE THERAPY SOLUTIONS, LLP

Dear Parents:

Hello and welcome to our Infinite Therapy Solutions Family! We are excited to get to know you and your child. While we can guarantee you our prompt and professional services there are a few details that will need to be stated and signed for below. In order to serve you better it is important that these courtesies do not go without discussion.

please initial at every line

A signature sheet will need to be signed by the parent or guardian at each session. _____

All cancellations MUST be made 10 hours before the scheduled visit or you may be charged $150_____

All visits are 45 minutes of direct service followed by 15 minutes "Explain and Train" and documentation_____

If visits are taking place at home a parent or guardian MUST be present at each visit _____

Clinicians will NOT accept copayments or insurance payments (out of network benefits checks will be mailed to you directly)_____

Subscriber will receive checks directly and are responsible for bringing it to ITS Clinic directly (may leave in secure mailbox)_____

If visits are taking place at home, for optimal care please provide a clean, unobstructed area for ITS treatment sessions_____

Regards,

Infinite Therapy Solutions, LLP