THERAYOUTH
TheraYouth Foundation

therayouth.org | Email: info@therayouth.org | Phone: 908-662-1000 | Fax: 973-385-8226

Patient Intake Form

Please take a moment to fill out our intake form before your visit. All information is kept completely confidential.

Patient Information:

First Name: _____ Last Name:_____

Date of Birth (MM/DD/YYYY) _____ Social Security Number: _____

Address: _____ City _____

State/County _____ Zip Code_____

Phone: Daytime/Cell _____ Evening _____

Email: _____

If Child, Parent/Guardian's Name: _____

How did you hear about TheraYouth? _____

Who referred you to TheraYouth? _____

Physician's Information: Name_____

Physician's Phone_____ Physician's Fax _____

In case of emergency, please provide us with 2 emergency contacts:

First Name: _____ Last Name:_____

Phone: _____ Email: _____

Relationship: _____

First Name: _____ Last Name:_____

Phone: _____ Email: _____

Relationship: _____

Do you require any special assistance? (Parking needs, mobility issues, allergies/sensitivities):

Yes_____ No_____ If yes, please specify:_____

_____

Employer: _____ Occupation: _____

Address:_____ City _____

State/County _____ Zip Code_____

Patient Insurance Information

Primary Insurance Carrier Name _____
Subscriber's: First Name:_____ Last Name:_____
Subscriber's Date of Birth (MM/DD/YYYY) _____
Relationship to the Subscriber: _____
Subscriber's Address (if different from patient): _____
City _____ State/County _____ Zip Code_____
Phone: _____ Email: _____

Secondary Insurance Carrier Name (if applicable) _____
Subscriber's First Name: _____ Last Name:_____
Subscriber's Date of Birth (MM/DD/YYYY) _____
Relationship to the Subscriber_____
Subscriber's Address (if different from patient): _____
City _____ State/County _____ Zip Code_____
Phone: _____ Email: _____
Is this an automobile accident: Yes_____ No_____ Case #:_____

Credit Card Information

Add a credit card. TheraYouth Foundation requires that you put a card on file for contactless payments. This helps keep both you and us safe, as well as spend more time with you, rather than taking a payment after your session.

We accept Visa, MasterCard, American Express, Discover, and UnionPay.

Card Number:	Expiration:

CVV:

☐ I am aware of the Cancellation Policy. I have read the Cancellation Policy.

Authorizations and Consent Form

THIS AGREEMENT is made between TheraYouth Foundation, A NJ NON PROFIT("Provider") and the parent or legal guardian of the Child concerning occupational, physical, speech therapy or other clinic-based services or other home-based services ("Services") provided to the Child listed above.

Release of Information to Other Professionals

I give permission for TheraYouth Foundation, A NJ NON PROFIT ("Practice") to exchange information about my child's evaluation, treatment, and/or progress with the person/facility listed below for the purpose of collaborating on my child's case. I understand that communication between TheraYouth Foundation, A NJ NON PROFIT and the person/facility named below may occur via phone, in-person conference, fax, postal exchange, and/or e-mail. I understand that the Practice will make every effort to exchange this information in accordance to HIPAA regulations. Please list the contact information individuals/organizations that you would like TheraYouth Foundation, A NJ NON PROFIT to share information with:

First Name: _____ Last Name: _____
Address: _____ City_____ State: _____
Contact Number: _____ Fax: _____
Email: _____

Signature: Date:

_____ _____

PHI Acknowledgement

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations or other applicable state or federal laws. I further understand that the Practice will not deny patient treatment if I refuse to sign this Authorization. If information is requested by patient's health insurer and I refuse to sign a required authorization, I understand that the health insurer may in certain instances deny patient payment, enrollment or eligibility for benefits, and that I therefore may be required to pay for the services out-of-pocket. I understand that I may inspect or request copies of any information disclosed by this authorization. Finally, I understand that I may revoke this authorization at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. I further authorize disclosure of my information via mail, e-mail, telephone, the internet or the facsimile machine (the risks of which have been explained to me) or as the Practice otherwise determines.

I hereby release TheraYouth Foundation, A NJ NON-PROFIT (its professionals, employees and agents, from all liability arising from this authorized disclosure of my health information. I understand that this authorization will expire 3 months after my child is discharged from the care of TheraYouth Foundation, A NJ NON-PROFIT. I have the right to cancel this authorization at any time by submitting a written notice of cancellation to TheraYouth Foundation, A NJ NON-PROFIT. Canceling an authorization does not change any release that occurred before the cancellation. I may request a copy of this signed authorization at any time.

Signature: Date:

_____ _____

Consents

Email Communication

Transactional Emails

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

☐ I would like email notifications of new, cancelled, and rescheduled appointments.

☐ Text Message (SMS) 3 hours before appointment.

News and Special Promotions

☐ Yes, I would like to receive important clinic updates, promotional offers, and educational resources by email.

Authorization and Consent Form — Consents

Accuracy of Information

☐ I certify that the shared medical information is correct to my knowledge. – *Required*

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

☐ I agree. – *required.*

Release of Information - Third Party Billing

I give the Practice permission to release necessary personally identifiable information to my health insurance plan and to a third-party billing service in order for my insurance to process the claims for services received at the Practice.

☐ I agree. – *required.*

Release of Information - Primary Care Physician

I give the Practice permission to release necessary personally identifiable information to my Primary Care Physician for services received at the Practice.

☐ I agree. – *required.*

Liability Release

This is to certify that I, on my own behalf and on behalf of my child, fully understand that there is a risk of personal injury to my child in participating in play-based activities and other physically active games through the occupational therapy and group services provided by the Provider. I am aware that my child is engaging in physically active games and/or therapeutic play-based activities which could result in injury to my child. I am voluntarily allowing my child to participate in these activities and assume all risks of injury that may result. I personally, and on behalf of my child, agree to hold no individual or corporation responsible or liable for any injury that my child receives on account of these activities, including, but not limited to TheraYouth Foundation, or its officers, employees, agents, aides, therapists, instructors, insurers, successors, or assigns (hereinafter "Releasees.") I further agree to waive any claims or causes of action against and to hold harmless said Releasees for any injuries or damages which my child suffers or might suffer as a result of the conduct of any person during or in conjunction with said physically active games or therapeutic play-based activities. I agree that my child is able to participate in a therapeutic play-based physical activities program and that it will not be detrimental or inimical to my child's health, safety, comfort, or physical condition and that of others if my child participates in said activities.

☐ I agree. – *required.*

Signature: Date:

_____ _____

Email Policy

I give permission to the Practice to send me appointment reminders and other information not containing personal health information via e-mail. I understand that the information sent via email is not secure. I understand that if I want to receive personal health information electronically, I will have to sign up for the Practice's patient portal.

☐ I agree – *required*

Scheduling Policies

The total amount of time allotted for a therapy treatment session is 30-60 minutes.

In order to receive the maximum benefit from treatment, it is important for treatment to occur as scheduled. Clients are encouraged to reschedule any canceled treatments to ensure the continuation of services and progress. Notifications of vacations and/or family obligations are requested at least two weeks prior to the expected absence to facilitate rescheduling our appointment(s). If your therapist is absent or the clinic is closed (holiday, inclement weather), TheraYouth Foundation will attempt to provide a substitute therapist to ensure the continuation of services. The make-up session offered may be on a different day or time than your usual scheduled weekly treatment.

☐ I have read and agree to abide by the above policies. – *required.*

Office Policies

The Parent/Guardian is responsible for waiting with the child in the waiting room until the session begins and for monitoring play in the waiting room, as well as abiding by all posted waiting room policies. It is preferred that the guardian remains in the waiting room for the session. If the guardian leaves during the session, the therapist must be notified and provided with a telephone number for use in the case of an emergency. It is expected that the guardian returns 15 minutes before the scheduled end time of the session to be available for consultation, home programming, and/or observation of treatment activities. Please note that any specific health and safety protocols (i.e. COVID-19) may supersede the waiting room policies.

☐ I have read and agree to abide by the above policies. – *Required*

If TheraYouth Foundation is an out-of-network provider. The client is responsible for understanding the individual insurance benefits and requirements, and for submitting the paperwork necessary for reimbursement. Health insurance companies do not guarantee benefits until claims are fully processed. TheraYouth Foundation will provide all billing statements, receipts, and medical notes necessary to help obtain reimbursement.

☐ I have read and agree to abide by the above policies. – *Required*

Cancellation Policies

TheraYouth Foundation requires a minimum of 24 hour notice to cancel appointments. Cancellations can be done online in your Jane Clinic Management Software My Account or by contacting the TheraYouth Foundation office at 908-662-1000 and leaving a message.

“No Shows” or cancellations for any reason, including illness, within a 24 hours window are subject to a fee equaling the cost of the scheduled service. This payment will be credited to your account and will be used if a makeup session (Telehealth or in clinic) or a Parent Coaching session is completed within two weeks of cancellation.

Two absences (not canceling within 24 hours and/or no shows) in a row will result in a loss of a scheduled time slot and a discharge from services at TheraYouth Foundation. If you are aware of an extended absence period and should wish to reserve your spot, you can do so for a holding fee of $10 per session. Missed treatment time due to late arrival, early departure, or the client’s inability to complete the session is subject to a charge equaling the entire scheduled appointment time. The medical billing codes will only reflect the actual treatment time.

☐ I have read and agree to abide by the above policies. – *Required*

Signature: _____ Date: _____

Media Consent and Release Form

I understand that THERAYOUTH FOUNDATION Clinic, is a charitable organization which depends upon public financial support to operate its clinics, because it makes no charges to its patients or families for services it renders. I also understand that the TheraYouth Foundation Clinic engages in public relations programs and fundraising programs designed to make the public aware of the clinic's needs, which include financial support, and to inform the public of the availability of the clinic's services.

I have been asked for permission to use photographs, audios or similar 'likenesses' of my child if I am the child's parent or legal guardian, in the TheraYouth Foundation Clinic's public relations programs and fundraising programs, and I have been assured that permission is not required as a condition to my child receiving therapy services at the clinic.

I wish to help TheraYouth Foundation Clinic in its public relations and fundraising programs, and I consent to photographs, slides, television, videotape, or motion pictures (called 'likenesses') being taken of my child or parts of his or her body, for public relations and fundraising purpose, subject to the following conditions:

(1) The last name of either the child or the parent or guardian will not be used to identify the 'likenesses', unless I/we have initialed here: _____.
(2) the 'likenesses; will be taken only with the consent of the treating therapist(s) and/or the clinic director and under conditions, and at times, as may be approved by them.
(3) The 'likenesses' will only be used in fundraising and Public Relations Media for five years from the date I signed this consent.

I can revoke this authorization at any time by notifying THERAYOUTH FOUNDATION Clinic. However, revoking this authorization will not affect any material that was already distributed based on my previous authorization.

I also understand that these 'likenesses' may be distributed by other people (such as passing on their copy of a 'likeness') and THERAYOUTH FOUNDATION Clinic, has no way to prevent this from happening. I have been given an opportunity to ask questions about this authorization, and either had no questions or they have answered to my satisfaction.

I expect no payment or anything else valuable for signing this authorization. Also, this authorization as to any use of photographs, slides, television, videotapes or motion pictures will expressively release from liability to me the person obtaining the 'likeness', the treating therapist(s), the clinic and all its personnel at THERAYOUTH FOUNDATION Clinic.

_____ I wish for my child's picture to be used.

_____ I do not wish for my child's picture to be used.

Signature: Date:

_____ _____