Child's Name: ________________________________
Date of Birth: ________________________________

8200 Homer Dr. STE. F
Anchorage, AK 99518
907-345-0050 Phone 907-344-5103 Fax

Erin Cowell OTR/L
Tracey Keaton M.S. CCC/SLP

NEW PATIENT INTAKE FORM

PERSONAL INFORMATION

Child's Legal Name:____ Date of Birth: ________

Age: _______ Male: _______ Female: _______

Mother or Legal Guardian: ________________________	**Father or Legal Guardian**: ____________________
DOB: ___________	DOB: ______________
Home Ph.:_____________________________________	Home Ph.:_________________________________
Cell Ph.:_______________________________________	Cell Ph.:__________________________________
Work Ph.:_____________________________________	Work Ph.:_________________________________
Best number to reach you at: __________________	
Physical Address: ______________________________ ______________________________	Physical Address: _________________________ _________________________
Mailing Address: _______________________________ _______________________________	Mailing Address: __________________________ __________________________
Zip: _________	Zip: _________
Occupation:____________________________________	Occupation:________________________________
Employer:_____________________________________	Employer:__________________________________
Address: _____________________________________ _____________________________________	Address: __________________________________ __________________________________

Child resides with? ____

Who has custody of the child? ____

If primary person bringing child to therapy is not listed above, please list name and contact phone number of that person.____

EMERGENCY CONTACT: ____
NAME: ____ **PHONE:** ___________________________
RELATIONSHIP:

<u>INSURANCE INFORMATION</u> (please fill out ALL areas)

Primary Insurance: ____________________________	Secondary Insurance:_____________________
Policy Number: ________________________________	Policy Number: __________________________
Group Number: ________________________________	Group Number: __________________________
Claims Address: ________________________________ ________________________________	Claims Address: __________________________ __________________________
Phone Number: ________________________________	Phone Number: __________________________
Insured's Name: _______________________________	Insured's Name: _________________________
Insured's DOB: _____________________________	Insured's DOB: ________________________

Child's Name: ________________________________
Date of Birth: ________________________________

Emergency Medical Release
In the event medical attention is required for your child while on the premises of AFKPT, LLC, we need your authorization to implement treatment. Please read and sign statement below.

As legal guardian of _______________, I give my permission for AFKPT, LLC to contact emergency personnel in the event of a medical emergency.
Parent/Legal Guardian Signature _______________________________________Date___________

MEDICATION/ALLERGY/CONDITION FORM

Medication: Please include prescription drugs, over the counter medication, vitamins, and homeopathic medications.
____

____

Allergies/Reactions:
____

____

Diagnosis: Please indicate any medical diagnosis or medical condition below:
____

____

PHOTO PERSMISSION **Initial/Date**

1. I give permission for photograph/videotape of my child for the purposes of treatment, education, and documentation. ___/___
2. I give permission for photograph/videotape of my child to be used for advertising, brochure and/or webspace. ___/___

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA):
I acknowledge that I have received a copy of the Privacy Practices that state the rights of patients and/or a patient's parent/guardian. **Signature:** ______________________________________**Date:** ___________

AUTHORIZATION AND CONSENT FOR TREATMENT, PAYMENT, AND OPERATIONS:
Please initial the following statements:
_____ I have a prescription from my child's physician to authorize initial evaluation.
_____ I have checked with my insurance company prior to this therapy visit and assert that I have obtained the necessary information regarding limits of coverage, co-pays and co-insurance.
______I hereby give All For Kids Pediatric Therapy, LLC permission to evaluate and treat my child, and understand there will be written, oral, and electronic communication between care providers/physicians, insurance companies, and All For Kids Pediatric Therapy, LLC staff. I understand that state representatives for the purpose of insurance certification or licensing and quality assurance may review my child's records. I understand that all practices of confidentiality will be followed in use of the information gathered.

______ I give All For Kids Pediatric Therapy, LLC permission to submit bills directly to the insurance carrier.
______ I have read and agree to follow All For Kids Pediatric Therapy, LLC office and financial policies.

____ ________________________
Signature of Parent/Gaurdian of patient **Date**

Who referred you to our office? ____

Childs primary care physician**:** ____

Child's Name: ________________________________
Date of Birth: ________________________________

List the names of the Programs and people that have worked or are working with your child. Please send latest evaluation and/or IEP for your child.

Service	Program Name	Teacher/Therapist	Phone #	Dates
Pediatrician/Physician				
Child Care Program				
Preschool				
School				
Occupational Therapist				
Speech Therapist				
Physical Therapist				
Counselor/psychologist				
Infant Learning Program				
Head start Program				
Caseworker/care coordinator				
Dietitian				
Other				

I hereby authorize any prior or present treating physician, therapist, School, hospital or other health institution, to release all of medical information by any means of communication to All For Kids Pediatric Therapy LLC.

______________________________________ ______________________________

Signature of Parent or Guardian **Date**