BEYOND BOUNDARIES
THERAPY SERVICES

Today's Date:____/_____/_____

Completed by: _____

Relationship to Patient: _____

Patient Name: _____ Gender: ___Female ___Male
First Last MI

Patient DOB: _____/_____/_____ Age: _____ Referral Source:_____

Physician:_____Location:_____

Patient's Address: _____

City:_____ State: _____ Zip:_____

Who will be with the adult patient for sessions:

Name: _____

Phone: _____

Home ( ) _____

Cell ( ) _____

Work ( ) _____

Email _____

Employer_____Occupation_____

In case of an Emergency, contact_____ Phone __(_____)_____

INSURANCE INFORMATION ****** A copy of the front and back of insurance card(s) are required ******

☐ Private ☐ Medicare ☐ Medicaid ☐ Friendship/Fraser/ICFMR ☐ None	☐ Private ☐ Medicare ☐ Medicaid ☐ Friendship/Fraser/ICFMR ☐ None
PRIMARY Insurance: _____	**SECONDARY** Insurance:_____
Insured's Name: _____ DOB_____	Insured's Name: _____ DOB_____
ID# _____ Group #_____	ID# _____ Group #_____

ASSIGNMENT AND RELEASE

_____Beyond Boundaries Occupational Therapy, Inc. (Occupational Therapy & Physical Therapy)

_____Beyond Boundaries Speech Language Therapy, Inc.

I hereby authorize payment directly to the above for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of responsible party_____Date_____

Billing statement should be mailed to:

Name: _____ Phone:_____

Address:_____

City_____ State_____ Zip _____

BEYOND BOUNDARIES
THERAPY SERVICES
3001 11TH St. So., P 701.356.0062
Fargo, ND 58103 F 701.356.5412

ADULT
Needs Assessment / Case History

Form Completed by: _____

Name: _____ DOB: _____ Age: _____ Gender: Male/Female

Doctor: _____ Date of Last Doctor Visit: _____

Current physician(s): _____

Current Medical Diagnoses:_____

Allergies: _____

Sleep: Hours per night _____ Naps (# and length) _____ Any difficulty with sleep _____

Current medication(s) including supplements and over the counter medications:_____

Any recent accident / injury / incident (within the last 6 months): _____

Any hospitalizations / surgeries (include dates): _____

Current physical limitations: _____

Are there any precautions or contraindicated activities _____

Special equipment or assistive technology that you use: _____

If so, please bring with you at the time of the evaluation.

PAST THERAPY

Have you received previous therapy evaluation and/or treatment: _____ no If yes → ____ OT ____ PT ____ Speech

If so, when? _____ where?_____ for how long? _____

Goal areas addressed _____

Response to past therapy intervention _____

CLIENT RESPONSE:

My strengths are _____

I enjoy _____

I wish it were easier to _____

What would you like to learn from this evaluation?_____

What is your primary concern at this time?_____

CAREGIVER CONCERNS (if applicable):

What would you like to be easier for you? _____

What would you like to learn from this evaluation?_____

What is your primary concern at this time?_____

BEYOND BOUNDARIES
THERAPY SERVICES
3001 11th St. So. Fargo, ND 58103
Phone: (701) 356-0062 Fax: (701) 356-5412

HIPAA Disclosure Form

Patient Name_____ DOB_____

Dear Patients,

We consider the privacy of your health information to be one of the most important elements in our relationship with you. Our responsibility to maintain the confidentiality of your health information is one that we take very seriously. We have taken the following steps to protect your privacy.

We train our staff members on their responsibility to maintain the confidentiality of your health information and hold them accountable for their actions. We do not sell your information to any organization.

Federal legislation concerning patient privacy requires health care providers, health insurance companies and other health-related organizations to bolster their privacy practices as of April 14, 2003.

We are pleased to provide this information to our patients and to comply with the privacy regulations of the federal Health Insurance Portability and Accountability Act (HIPAA).

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment. I understand that Beyond Boundaries Therapy Services will keep medical records for 5 years from the start of care.

_____ _____
Print Name Relationship to Patient

_____ _____
Signature Date

A parent may change status at anytime by calling the office at 701-356-0062. Thank you!

BEYOND BOUNDARIES
THERAPY SERVICES
3001 11th St. So., Fargo, ND 58103
Phone: (701) 356-0062 Fax: (701) 356-5412

Authorization to Share and Release Information

PATIENT'S NAME: _____ DATE OF BIRTH:_____

I hereby authorize the following to share information regarding evaluations, treatment notes, progress notes and insurance information regarding my child (named patient above) for the purposes of treatment planning and coordination of services. I hereby authorize the following agencies/individuals to disclose information to and exchange information with the following entities. *Please initial below indicating your authorization and knowledge of this.*

_____ *Beyond Boundaries Occupational Therapy, Inc. (Occupational Therapy & Physical Therapy)*
_____ *Beyond Boundaries Speech Language Therapy, Inc.*

I understand that my health information is protected, confidential and will be shared only with medical personnel as pertains to my medical care. This ROI will be in effect until parent request of change of status of ROI and/or if patient is discharged from services. Indicate specific names below.

Sanford Health System	Physician Name:
Essentia Health	Physician Name:
Pediatric Arts Clinic	Physician Name:
Independent Family Doctors	Physician Name:
Respite/Agency	Provider Name:
Southeast Human Service Center	Case Manager Name:
Early Intervention Program	Case Manager Name: Provider Name:
School	Case Manager Name: Teacher/Therapist Name:
Cass/Clay County Social Services	Case Manager Name:
Daycare	
Relatives	
Other	

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Signature of Witness Date

BEYOND BOUNDARIES
THERAPY SERVICES

3001 11th St. So. ● Fargo, ND 58103
Phone (701) 356-0062 Fax (701) 356-5412

Parent Consent

PATIENT NAME:_____ PATIENT DOB: _____

CONSENT FOR STUDENTS / VOLUNTEERS

As a clinical teaching facility, Beyond Boundaries Therapy Services provides the opportunity for undergraduate and graduate students in the therapy field as well as volunteers to observe and participate with care under the direction of a registered and licensed therapist. All volunteers and students sign a confidentiality agreement prior to starting any observations.

An undergraduate student may be in need of volunteer hours, an internship, or clinical observation. A graduate student has the opportunity to complete Level 1 (5 days) and Level 2 (12 weeks) clinical rotations. Level 1 rotations mainly consist of student observation. With the Level 2 clinical rotation, the graduate student is expected to participate in the treatment planning as well as the direct therapy process.

By signing below, you are giving permission for volunteers and/or students to be a part of your child's therapy session.

___ YES, I give permission for volunteers, undergraduate, and graduate students to be a part of my child's therapy session.

___ I do not give permission for volunteers, undergraduate, and graduate students to be a part of my child's therapy session.

PHOTO / VIDEO POLICY

I have been informed that a picture is required for the medical chart. Photos and videos will be used if necessary for treatment purposes only. Consent for additional use of photo/video will be obtained prior to sharing outside of Beyond Boundaries Therapy.

SUBSTITUTE THERAPIST

I have been informed that there may be instances in which the primary therapist may be unavailable (illness, family emergency, etc.). Our policy is to schedule another qualified therapist with the client to carry out the current plan of care for that scheduled session. Any concerns relating to this policy, please inform the therapist or the office staff.

_____ _____
Print Name Relationship to Patient

_____ _____
Signature Date

A parent may change status at anytime by calling the office at 701-356-0062. Thank you!