



Client Intake Form

Client Name _____ DOB ____/____/____ Female Male
Client Address _____
City _____ State _____ Zip _____
Phone _____ Email _____

Please indicate who Beyond Boundaries may communicate with regarding this client’s therapy care including schedules and updates (check all that apply). Billing information will be shared only with mother, father, or legal guardian as authorized.

Mother’s Name _____ N/A
Father’s Name _____ N/A
Other Legal Guardian _____ N/A
Other _____ N/A

INSURANCE

****A copy of the front and back of your updated insurance card(s) are required to be on file at Beyond Boundaries****

Primary Insurance _____ ID# _____
Policy Holder _____ DOB _____
 No Yes, Secondary Insurance _____ ID# _____
Policy Holder _____ DOB _____
 No Yes, Third (Tertiary) Insurance _____ ID# _____
Policy Holder _____ DOB _____

CONTACTS

In case of an emergency, contact _____ Relationship _____
 Cell _____ Work _____ Home _____
 N/A Respite Worker Name _____ Phone _____
 N/A Foster Parent(s) Address _____
Foster Mother _____ Phone _____
Foster Father _____ Phone _____

For adult clients, name of caregiver who will attend sessions:

Name _____ Phone _____
School client attends _____ Phone _____

Does client have an Individualized Education Plan? No Yes (please provide a copy to Beyond Boundaries)

Other than parents / legal guardian, who do you authorize to pick up this client?

Name _____ Phone _____

Name _____ Phone _____

APPOINTMENT REMINDERS

Beyond Boundaries Therapy cancellation / no-show policy indicates: **Cancellation:** If it is necessary to cancel a therapy session, you must provide a 4-hour advanced notice or a charge of \$50 per missed therapy session will be billed. The exceptions to this would be; **unexpected illness, family emergency, and inclement weather.** If illness affects the client's treatment plan, a physician's note will be required. **If you reschedule this appointment within 5 business days, there will be no charge.**

No-Show: If a client does not attend a scheduled therapy session a fee of \$50 per therapy session will be charged (this includes schools, daycares, and home visits). More than 3 no-shows per therapy could result in discharge from that service.

As a courtesy, Beyond Boundaries provides appointment reminders to help avoid unplanned cancellations and no-shows. Please indicate below how you would like to be reminded of appointments.

I am aware of the above fees, however, would NOT like a reminder for appointments.

I would like a reminder sent to me by:

Email _____

Voice Reminder Call to Phone __ (____) _____

Text Reminder __ (____) _____ Cell phone Carrier _____

If opting to choose text reminder, please be aware that message and data rates may apply. If you have an unlimited text messaging plan, then you don't have to worry.

We are happy that you have chosen Beyond Boundaries Therapy Services. Who can we thank for referring you?

Self Website Facebook Web search Other _____

TV Magazine (which one) _____ Radio (which station) _____

Medical Professional }
 Friend/Family } Name: _____
 School/Daycare }

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Beyond Boundaries Occupational Therapy, Inc. (Occupational Therapy & Physical Therapy) and Beyond Boundaries Speech Language Therapy, Inc. for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, not covered 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.

Printed name of responsible party _____

Signature of responsible party _____ Date _____



BEYOND BOUNDARIES
THERAPY SERVICES

3001 11TH St. So. P 701.356.0062
Fargo, ND 58103 F 701.356.5412

PINK CASE HISTORY

---NEW PATIENT---
INDIVIDUALIZED NEEDS ASSESSMENT
CASE HISTORY FORM

___OT ___Speech ___PT

Date _____

Client Name _____ Parent / Caregiver Name _____

DOB: _____ Age: _____ Grade _____ Gender: Male Female

Is there a language other than English spoken in the home? yes no What language? _____
If yes, does the child speak this language? yes no Does child understand this language? yes no

Number of children in family and ages: _____

Who lives in home with client / caregiver/family status (ie married, coparent, single, split custody)? _____

How did you hear about Beyond Boundaries? _____ Who were you referred by: _____

Primary Care Physician/Pediatrician: _____ Date of Last Doctor Visit: _____

Current Medical Diagnoses: _____

Reason for Referral: _____

PARENT / CAREGIVER HISTORY OF CONCERNS

What would you like to be easier for your child and helpful for home and daily life? _____

What is your primary concern at this time? _____

What are your child's strengths? _____

Any concerns with sibling interactions? yes no If yes, please describe _____

Has your child received previous therapy evaluation and/or treatment? yes no If yes OT Speech PT
If so, when? _____ Where? _____ For how long? _____

Please specify areas that were addressed during previous treatment _____

When did you first notice your child having difficulty? _____

Is the child receiving any other outside services? counseling psychology chiropractor behaviorist autism specialist
early intervention other _____

PREGNANCY AND BIRTH

Child was born full term premature If premature, how many weeks? _____

Delivery vaginal with forceps c-section Were there any complications? _____

Was your child placed in the neonatal intensive care unit? yes no If yes, how long? _____

Please describe any other medical problems or complications at birth _____

MEDICAL HISTORY

Allergies? yes no If yes, please describe _____

Hospitalizations? yes no If yes, please describe _____

Surgeries? yes no If yes, please describe _____

Recent vision exam? yes no Date _____ Results _____ Dr. _____ Glasses: yes no

Recent hearing exam? yes no Date _____ Results _____

PE Tubes placed in the middle ear? yes no If yes, when? _____ Physician who inserted the tubes _____

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

Current physical limitations: _____

Are there any precautions or activities child should not participate in? _____

Special equipment or assistive technology used: _____

DENTAL /ORAL HISTORY

Has your child been seen by a dentist? yes no If yes, how often? _____ Date of last visit _____

Any difficulties at the dentist? _____

Has your child ever used a pacifier? yes no Does he/he still use a pacifier? yes no

Does your child choke or have difficulty swallowing food or liquid? yes no If yes, please describe _____

Does your child put toys or objects in their mouth? _____

Does your child brush his/her teeth? yes no Does he/she allow you to brush his/her teeth? yes no

NUTRITION, FEEDING, CONTINENCE & SLEEP

Has your child had any unusual feeding / dietary problems? yes no If yes, please specify? _____

Do they choke/cough while eating? yes no Any food allergies? yes no

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

If your child is age 5 or older, does he/she wet during the day wet at night experience constipation Not a concern

DEVELOPMENTAL HISTORY – COMPLETE FOR CHILDREN AGES 0-5

Please indicate at what approximate age your child achieved the following milestones:

*Mark N/A for those which your child has not yet achieved.

_____ Rolled over

_____ Sat alone

_____ Crawled

_____ Pulled to stand

_____ Cooed (vowel sounds)

_____ Babbled (consonants heard)

_____ Said first word

_____ Drank from a cup

_____ Drank from a straw

_____ Followed 1-step direction

_____ Followed 2-step direction

_____ Pointed to objects

_____ Stood alone

_____ Used two words together

_____ Spoke in short sentences

_____ Used a spoon

_____ Toilet trained

_____ Dressed self

_____ Walked alone

_____ Identified family members

EDUCATIONAL INFORMATION

School/Educational program currently attending: _____ Present grade level: _____

Special services received in school: _____ Does your child have a current IEP? yes no

Community participation/extracurricular activities: _____

Leisure activities at home: _____

Comments/Additional information: _____

COMMUNICATION / SOCIAL-EMOTIONAL DEVELOPMENT

How does your child communicate? pointing/gestures sounds words phrases sentences

Does your child understand what you say? yes no

Does child answer "wh" questions appropriately? yes no

Does your child interact well with others? yes no

Does child answer yes/no questions appropriately? yes no

Do your family members understand your child? yes no

Does your child have any trouble making friends? yes no

Does your child show appropriate eye contact? yes no

Does your child demonstrate safety awareness? yes no

Does your child follow 1-2 step multi-step directions? yes no

Does your child transition easily? yes no

Does your child have difficulty calming himself/herself when upset? yes no

Does your child become upset and/or frustrated when unable to communicate wants, needs, and thoughts? yes no

Are you able to identify certain triggers for your child? _____

Fears/coping behaviors _____

Additional comments: _____

PLAY SKILLS

Check areas of difficulty:

plays well with siblings has friends has play dates difficulty with winning/losing attention span

other _____

BEHAVIOR

Please check any of the following that apply:

___ Cries often

___ Dislikes hair brushing

___ Rocks self

___ Frequent temper tantrums

___ Dislikes tooth brushing

___ Sensitive to light or sound

___ Anxious

___ Avoids touch from others

___ Aggressive (biting, hitting)

___ Trouble following directions

___ Dislikes playground equipment

___ Poor attention span

___ Trouble with changes in routine

___ Seems to be "on the go"

___ Mouths objects

___ Clumsy, tripping, falling

___ Weak muscles

___ Picky eater

___ Dislikes certain clothing textures

Other: _____

What makes the symptoms better? _____

What makes the symptoms worse? _____

PARENT / CAREGIVER CONCERNS

Is there anything else you would like us to know about your child that has not been addressed in the previous questions?

If child is being evaluated for OT or PT (occupational or physical therapy).....
 Please check any of the following performance skill areas that you child is having difficulty with.

| VISUAL PERCEPTION | |
|---------------------------------------|--|
| | Inattention and distractibility to written and/or reading tasks. |
| | Difficulty writing, reversal of letters such as b for d or p for q |
| | Difficulty copying from a blackboard or a whiteboard |
| | Difficulty with puzzle pieces – gives up |
| SELF CARE | |
| | Dressing: clothes or shoes on backwards , shoes on wrong feet |
| | Food pushed off plate, messy eating |
| | Needs assistance with toileting (ie clothing, wiping) |
| SOCIAL SKILLS | |
| | Withdrawal from social situations |
| | Poor eye contact |
| | Lack of confidence in oneself |
| | Poor body language |
| | Making friends / getting along with others |
| FINE MOTOR | |
| | Difficulty holding pencil or utensil / awkward grasp |
| | Unable to complete mazes, dot-to-dots, etc. |
| | Poor scissor skills |
| | Difficulty holding or avoids small objects, pencils or scissors |
| GROSS MOTOR (MOTOR AND PRAXIS SKILLS) | |
| | Flinching or other responses when catching a ball |
| | Fear response to gross motor activities |
| | No motivation or avoids gross motor activities |
| | Unable to hop, skip, jump, run, etc. |
| | Difficulty maintaining balance while walking, trips or falls often |
| | Difficulty coordinating both sides of body |
| | Problems planning and carrying out new actions, difficulty forming a idea or developing new motor skills |
| SELF-REGULATION | |
| | Responding to the feelings of others by acknowledgement or showing support |
| | Controlling anger toward others and reducing aggressive acts |
| | Recovering from a hurt or disappointment without lashing out at others |
| | Displaying emotions that are appropriate for the situation |
| | Persisting in task despite frustrations |
| | Difficulty calming down |
| | Over-responsive to sensation, fight or flight response to sensation (aka sensory defensiveness) |
| | Under-responsive to sensation, seem to have an continuous desire for sensory stimulation |



3001 11th St. So., Fargo, ND 58103
701-356-0062

**HIPAA Disclosure Form /
Notice of Privacy Practices**

CLIENT NAME: _____

CLIENT DOB: _____

We consider the privacy of 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).

Notice of Privacy Practices. Please initial below.

1. I understand that clients may be seen by a licensed therapy assistant and/or one of our clinical students under the direct supervision of a licensed therapist.
2. To comply with HIPAA rules and regulations, please understand that Beyond Boundaries staff is not encouraged to communicate through personal Facebook and/or other personal social media with clients.
3. Beyond Boundaries may:
 - a. Call my cell, home or other alternative location and leave a message on voicemail about client’s therapy care.
 - b. Mail to my home or other alternative location any items that assist in carrying out therapy care such as patient statements.
 - c. Email to my home or other alternative location any items that assist in carrying out therapy care such as therapy updates, home programs, progress reports and appointment reminders.
 - d. Leave a communication card (handwritten note with session update) in client’s personal cubby area at site outside of Beyond Boundaries (ie daycare, school).
4. 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.
5. I understand and agree 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.
6. I acknowledge and agree to the open treatment areas used by Beyond Boundaries Therapy and understand that a private treatment area may not always be available.
7. I agree and understand that other patients will be completing treatment during my visit and may overhear information regarding client’s plan of care.

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of Beyond Boundaries Therapy Notice of Privacy Practices. I further acknowledge that this notice as well as any amended Notice of Privacy Practices will be posted at Beyond Boundaries Therapy. I understand that Beyond Boundaries Therapy Services will keep medical records for 5 years from the start of care. By signing this form, I am consenting to allow Beyond Boundaries Therapy to use and disclose client’s personal health information to carry out therapy treatment plan of care. I understand that I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Print Name

Signature

Relationship to Patient

Date

| OFFICE USE ONLY | |
|--|--|
| Beyond Boundaries Therapy attempted to obtain written agreement for HIPAA Disclosure Form / Patient Consent, but acknowledgement couldn’t be obtained because: | |
| <input type="checkbox"/> | Individual refused to sign |
| <input type="checkbox"/> | Communication barrier prohibited obtaining signature |
| <input type="checkbox"/> | Emergency prohibited obtaining signature |
| <input type="checkbox"/> | Other (please specify) _____ |
| _____ | _____ |
| Authorized Beyond Boundaries Signature | Date |



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

Authorization to Disclose/Exchange Protected Health Information
Release of Information (ROI)

CLIENT'S NAME: _____ DATE OF BIRTH: _____

Communication with the primary doctor is required for treatment planning and care.

PRIMARY DOCTOR: _____ at _____ Facility

In addition to the Primary Care Provider listed above, I authorize the following to disclose information to and exchange information with Beyond Boundaries Occupational Therapy, Inc. (Occupational Therapy & Physical Therapy) and Beyond Boundaries Speech Language Therapy, Inc.

Below, please indicate entities authorized to disclose/exchange protected health information:

- Essentia Health, Sanford Health, Other Medical Facility / Clinic, Southeast Human Service Center, Cass/Clay County Social Services, NDSU - Hippotherapy Program

Name: _____

Psychology / Neuropsychology Name: _____

Community Agencies... please specify Fraser Friendship RR Human Services CLS MCRS Other _____

Respite Agency Name of Agency: _____

School Name of School: _____

Early Intervention Program... please specify Anne Carlsen Center Early Intervention Partners

Daycare Name of Daycare: _____

If information can be shared with other (parent or legal guardian), please indicate name and relationship below:

Other Name: _____ Relationship: _____

Check if you wish to have therapist(s) share session information with any of the following (check ALL that apply):

Grandparents Nanny/Babysitter Older Siblings Other _____

I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation is not valid if (1) action was previously taken in reliance on this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage. I authorize the facility/provider to disclose medical information to the party identified above. I understand that mental health, alcohol/drug use, and HIV treatment records would not be disclosed without further written consent. I understand that once disclosed, information may be re-disclosed by the recipient and is no longer protected. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment or my eligibility for benefits. This authorization expires one year from the date of my signature unless I specify a different event, purpose or alternative expiration date here: _____

Signature: _____ Date: _____ Time: _____

Relationship of Person Signing (if not patient): _____



Client Name: _____ Date of Birth: _____

BEYOND BOUNDARIES PAYMENT POLICIES

Careful, individualized planning and preparation goes into preparing your child for therapy services. At Beyond Boundaries Occupational Therapy, Inc (occupational therapy and physical therapy) and Beyond Boundaries Speech Language Therapy, Inc., we strive to maximize your child's potential and progress with consistent therapy sessions. Consistent attendance is essential to achieving your child's goals and receiving the full benefit of therapy. We want to provide the best experience for you and your child. Please read through our policies on attendance/billing. Our office staff can provide additional information/clarification as needed.

Cancellations & No-Shows (preparation time, 30-45 minutes blocked therapy time, documentation time)

- ❖ **All cancellations or reschedules must be done by calling the front desk at 701-356-0062.**
- ❖ Insurance cannot be billed for cancelled or missed therapy sessions.
- ❖ **Cancellation:** If it is necessary to cancel a therapy session, you must provide 4-hour advanced notice or a charge of \$50 per missed therapy session will be billed (***EXCEPTIONS: unexpected illness, family emergency, and inclement weather***). If illness affects the client's treatment plan a physician's note will be required. This fee will be charged on your statement. ***If you reschedule this appointment within 5 business days, there will be no charge.***
- ❖ **No-Show:** If a client does not attend a scheduled therapy session a fee of \$50 per therapy session will be charged (this includes schools, daycares, and home visits). More than 3 no-shows per therapy could result in discharge from that service.

Billing

- ❖ Billing statements will be mailed monthly and payment is due within **30 days**. We accept cash, check, HSA cards or major credit cards.
- ❖ Overdue balances may result in **services being put on hold and/or collections notification**.
- ❖ Payment plans/financial assistance plans can be arranged with the office manager at any time.
- ❖ If your insurance changes, you are required to notify the office in advance or you will be billed for services not covered by your new insurance.

Meeting/Consult Fee

If a parent or outside entity requests a therapist to be present at a meeting outside of Beyond Boundaries or to provide consultative services, a \$75 per hour fee will be charged. This fee helps to cover preparation, drive time and meeting time. If a progress note and 15-minute phone call would suffice, there will be no charge for the 15-minute phone call.

Printed Name: _____

Client or Parent/Legal Guardian Signature

Date