Circle Creek Therapy

Tel: 253.237.3405
Fax: 253.679.0488
circlecreek**therapy**.com

110 2nd St. SW, Ste. 110
Auburn, WA 98001

Pediatric Patient Intake

Please tell us which service(s) you're interested in for your child:

☐ Speech-Language Pathology ☐ Physical Therapy ☐ Occupational Therapy ☐ I'm not sure

Patient name: _____ DOB: _____/_____/_____

Address: _____
Street City State Zip

Contact name: _____
(Caregiver/Spouse/Parent/Significant Other)

Home phone: (_____) _____-_____ Work phone: (_____) _____-_____ Cell phone: (_____) _____-_____

E-mail: _____ Primary Language(s): _____

Please send appointment reminders via: _____ text message (SMS) _____ email

How did you hear about Circle Creek Therapy? _____

Physician

Primary physician: _____ Phone: (_____) _____-_____

Practice name: _____ Fax: (_____) _____-_____

Address: _____
Street City State Zip

Insurance

Primary insurance: _____ Benefits phone number: (_____) _____-_____

Member ID: _____ Group Number: _____

Policy Number: _____

Subscriber's name: _____ DOB: _____/_____/_____

Relationship to patient: _____

Employer: _____

Secondary insurance: _____

Concerns / Treatment History

Has your child had an evaluation or received therapy in the past? (circle one): YES / NO In: SLP / PT / OT

If yes, where has your child had previous evaluations or therapy: _____

What are your concerns for your child? _____

_____

Medical Information

Was your child born full term? _____ Premature? (weeks gestation) _____

Were there any complications during pregnancy or your child's birth? If yes, please explain.

_____

_____

Was your child late to meet any developmental milestones (sitting, walking, speaking, toilet training, feeding, reading, etc.)? _____

Please list any medical diagnoses: _____

Do you have any hearing and/or vision concerns? _____

Has your child had his/her hearing tested? _____ If yes, when? _____

Has your child had any reoccurring ear aches/ear infections? Y/ N Details: _____

Is there family history of developmental delays? _____

Has your child complained of any pain? (circle one): YES / NO

If yes, where is the pain located and how long has the child had this pain? _____

Are there any other signs or symptoms we should be aware of? _____

_____

Please list any medications your child takes: _____

Are immunizations current? _____

Does your child have any known allergies? _____

Please describe reactions. _____

_____
Patient or Parent/Guardian signature

_____ _____
Relationship to patient Date

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Policies & Procedures

We are so excited to have the opportunity to get to know you and your family and to help you improve your speech and language skills. Please take a moment to review the following policies and guidelines.

Communication release
I consent and agree that Circle Creek Therapy and its staff may contact me, leave voice messages, send me text messages and/or send me emails to the phone number(s) and email address(es) I have provided them. I understand that these messages can include protected health information, such as patient name, appointment information, billing information, information that identifies the practice as a speech therapy practice, and any pertinent clinical information. I understand that text messages and emails are not secure forms of communication, and that by consenting to these communication types, I am waiving my rights to secure electronic communications. Circle Creek Therapy may send me informative emails that contain newsletters, information about treatment alternatives or other health related benefits.

How to contact us
You can reach CCT via email or by phone. If you have questions about therapy, please communicate these in a timely manner with the clinician during the next visit, via email, or via phone. Please leave a message if your phone calls are not immediately answered; the team at CCT checks voicemails frequently. If you have any questions or concerns or notice changes and improvements, please share that with us! To leave a message after business hours, please call us at 253.237.3405.

Sessions
We offer 30-minute session slots. This is time spent with the patient directly working on therapy goals and can include consultative time with the caregiver. Our staff are professionals and have many patients requiring our services. The time that we schedule for you is yours and we value that time.

Attendance policies
We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule a visit for you, due to a seemingly “full” appointment book.

Patients who do not show up for their appointment without a call to cancel will be considered a “no show” and will be charged $40. Patients who “no show” two (2) or more times in a 6-month period, may be dismissed as a patient.

Office appointments which are cancelled with less than 24 hours notification are subject to a $40 cancellation fee. The cancellation and no show fees will be applied automatically to your account and are the sole responsibility of the patient. These fees are not covered by insurance. Fees must be paid in full before the patient’s next appointment. Fees may be reconsidered due to special, unavoidable circumstances, which may cause you to cancel within the 24 hours. We will be happy to excuse a late cancellation in the event of a fever, diarrhea, and/or vomiting within the last 24 hours.

Please contact us as soon as possible, or when you receive your appointment reminder, to cancel. If it is outside of office hours, please call and leave a voicemail, text (253.237.3405), or email us (kathy@circlecreektherapy.com or cdoherty@circlecreektherapy.com).

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Payment policy
It is the patient's responsibility to know what their insurance company and speech therapy coverage is. As a courtesy to you, Circle Creek Therapy will research your insurance benefits and inform you of your estimated costs. We will file your insurance claim for you as a courtesy if you are covered by one of the plans with which our clinic participates. Please check with your insurance carrier to verify that your insurance will be accepted and your plan covers speech therapy. If your insurance denies therapy and/or you have reached your maximum allowed benefit, you are responsible for the balance of your account. We do offer private pay agreements with discounts allowed for payment at time of service.

To facilitate payment for services, we ask that you keep us informed of any insurance and/or primary care physician changes. Failure to do so may result in a transfer of charges to you. Payment for office services, co-pays, co-insurances, and deductibles are due at the time of service. If you are unable to pay for your services on the date of your appointment, we will be happy to reschedule your appointment. Any outstanding balance beyond 30 days without payment may result in suspension of therapy until balance is paid in full.

Circle Creek Therapy accepts credit, debit, HSA, cash, or check. You will be charged a $30 fee for returned checks.

Please initial showing your consent:

_____ I consent to necessary examination procedures and/or treatment for myself or my child by Circle Creek Therapy, PLLC.

_____ I have been offered a copy of the HIPAA and Privacy Notice from Circle Creek Therapy, PLLC.

_____ I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of benefits to Circle Creek Therapy, PLLC and its therapists for services provided and claimed. I acknowledge that I am responsible for any fees not covered by insurance.

By signing this, I acknowledge that I understand and agree to the policies listed above.

_____ _____
Patient name Patient or Parent/Guardian signature

_____ _____
Relationship to patient Date