12545 Orange Drive - Suite 502
Davie, Florida 33330

BreakthroughTherapyServices
DEVELOPMENTAL BREAKTHROUGHS FOR CHILDREN

Phone: (954) 474 - 8048
Fax: (954) 474 - 8145
info@breakthroughtherapyservices.com

Client Intake Form

Date _____

Client Information

Patient Name _____

Date of Birth _____

Parents' Name: Mother _____

Father _____

Address _____

_____

Mother (H)_____ (C) _____

(W)_____ Email _____

Father (H)_____ (C) _____

(W)_____ Email _____

Primary Diagnosis _____Therapy Requested _____
Previous Therapy Location_____

Preferred Method of Communication (please number in order of preference 1, 2, and 3)

_____ Text Mom/Dad (circle one) _____ Email Mom/Dad (circle one)

_____ Cell Mom/Dad (circle one) _____ Other (_____)

Preferred Schedule (Circle all that apply):

Day(s) of the week: M Tu W Th F Sat

Time of Day: 9 10 11 12 1 2 3 4 5 6 7

Additional Comments: _____

Primary Care Pediatrician

Name _____

Phone # _____ Fax # _____

Address _____

_____

Insurance ****Please provide insurance card for copying**

Provider _____Policy Type _____

Member ID _____ Group # _____

Primary Cardholder's Name _____DOB _____

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Release of Information

I, _____, do hereby allow Breakthrough Therapy

Services to release Therapy information to

_____, regarding

_____.

_____ _____

Signature Date

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I, _____, do hereby allow Breakthrough Therapy Services to photograph, audio tape, and/or video tape my child _____.

_____ _____

Signature Date

I, _____, do hereby allow Breakthrough Therapy Services to use photographs, audio tapes, and/or video tapes of my child _____ for educational or advertising purposes.

_____ _____

Signature Date

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Dear Parents,

Please be advised that HIPPA requirements are mandated by the state governments. All medical and allied offices must comply with these regulations or face hefty fines. These requirements have been implemented and may require the signing of additional forms to be returned to Breakthrough.

Parents, family members, and caregivers are not permitted to enter into treatment areas when other children are being treated as this is a breach of patient confidentiality.

Parent observation of a particular session must be scheduled in advance to ensure that a specific treatment room is available.

Parents are not able to enter administrative areas under any circumstances.

Thank you in advance for your cooperation,

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Notice of Privacy Practices

I, _____, have been made aware in writing of my right to confidentiality regarding the treatment of my family member, _____ with Breakthrough Therapy Services.

_____ _____

Signature Date

Consent to Treat

I also agree to give consent to Breakthrough Therapy Services to treat the above named family member.

_____ _____

Signature Date

Cancellation Policy

Please cancel all appointments within 24 hours (emergencies excluded) in order to maintain appointment sessions and to prevent billing. If there are more than three instances (emergencies excluded) without 24 hour notice, your child will be pulled from scheduled therapy sessions the following week. Each instance will be reviewed on an individual basis. I am aware of the above policy.

_____ _____

Signature Date

Assignment of Insurance (including Medicaid) Benefits

I request that payment of authorized benefits be made to Breakthrough Therapy Services. I understand that I am responsible for any amount applied to the deductible, including the percentage of co-insurance and any non-covered services under the insurance program. Additionally, I am responsible for charges not paid by my insurance policy.

_____ _____

Signature Date

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Dear Parents,

Food/treats are often used as positive reinforcement for activity completion. Due to the vast amount of individualized/specialized diets and allergies we will not provide food or treats from the center. If you would like us to work on feeding goals or if you would like us to use treats as a positive reinforcement we ask that you supply your child with his/her own food. Food brought in will be labeled and kept at the therapy center for your child only.

*On special occasions we will have food available to children. Please list your child's allergies and diets below.

Child's Name: _____

My child is allergic to:

_____

My child is on the Gluten-Free (GFCF) diet: yes___ / no___.

Thank you for your cooperation,

Breakthrough Therapy Services