ELITE
THERAPY

1505 Renaissance Boulevard,
Edmond, OK 73013
Phone: (405) 850-8497 Fax: (405) 300-0643
www.elitetherapyokc.com

CLIENT INFORMATION: Today's Date _____

Patient's Name _____ Date of Birth _____
Address _____ City _____ **Zip** _____
Phone Number (home) _____ (work/cell) _____
Gender: _____ Current Diagnosis (list): _____
Physician _____ Phone number _____
Address _____ City/State/Zip _____

PRIMARY CONTACT (the person to call for scheduling apts. & additional info.)
Mother's name _____
Telephone (home) _____ (work/cell) _____
Address _____ City/State/Zip _____
Email _____
(by providing us your email you agree we can email you about appointments, billing, and/or newsletters)

Father's name _____
Telephone (home) _____ (work/cell) _____
Address _____ City/State/Zip _____
Email _____

PERSON MAKING THE REFERRAL (the person who told you about Elite Therapy)
Name _____ Relationship _____
Telephone (home) _____ (work/cell) _____
Address _____ City/State/Zip _____

SOONERCARE/MEDICAID INFORMATION (If applicable)

FULL NAME ON CARD _____ **ID#** _____

PRIMARY INSURANCE INFORMATION (for Private Insurance only)

Insurance Carrier _____ Subscriber name _____

Address _____ Phone number _____

Marital Status _____ Date of Birth _____

ID number _____ Group number _____

Employer Name _____

Address _____ Phone number _____

SECONDARY INSURANCE INFORMATION:

Insurance Carrier _____ Subscriber name _____

Address _____ Phone number _____

Marital Status _____ Date of Birth _____

ID number _____ Group number _____

Employer Name _____

Address _____ Phone number _____

Payment responsibility: I understand that I am financially responsible for all services and products rendered to me by Elite Therapy.

Insurance Authorization and Assignment: I hereby authorize Elite Therapy to furnish information to insurance carriers concerning my conditions and treatments and I hereby assign to the center all payments for services and products rendered to myself or my dependents. ***Private insurance may/may not reimburse you for the amounts charged. Please check with your insurance company. By signing, you are stating that you recognize Elite Therapy billing is due on a monthly basis, regardless of reimbursement to you through your insurance policy.**

Consent for treatment: I, or my representative, acknowledge(s) my need for evaluation and intervention for speech and/or occupational therapy services, as indicated.

_____ _____

Parent's/Legal Guardian's Signature Date

(A photocopy of the authorization and assignment shall be considered as valid as the original)

ELITE
THERAPY

1505 Renaissance Boulevard,
Edmond, OK 73013
405.850.8497

Consent for Evaluation and/or Treatment

I consent to the evaluation and/or treatment of_____ at Elite Therapy and authorize the qualified personnel thereof to perform such diagnostic procedures and administer such care and treatments as may be directed by the clinic policy or ordered and/or prescribed by the clinical staff person who is responsible for my child's care.

I acknowledge that I have been fully informed of evaluation procedures; care and treatment of my child, and any risks associated with it have been addressed to my satisfaction. I understand that I may be asked to participate in my child's therapy/evaluation.

I understand that the professionals and staff of Elite Therapy are required by Oklahoma law to report reasonable suspicions of child maltreatment. I understand that if I or my child is in danger of hurting ourselves or others, this information may be reported in order to obtain appropriate protection. I understand that professionals and staff of Elite Therapy will keep records and information regarding my child's treatment confidential, except as authorized by me, as required by law, or as needed to protect persons from harm and to respond to reasonable suspicions that harm has occurred. I understand that Elite Therapy professionals and staff may share information among themselves for the purposes of coordinating care and for other purposes necessary to carry out regular clinic operations. I understand that the information shared will be the minimum necessary to carry out these activities.

I give permission for the person who brings my child for an evaluation and/or treatment to provide and to receive information concerning him/her.

I understand and agree that the professionals and staff of Elite Therapy, when services are billed to a 3rd party insurance provider, will contact and provide information to my insurance carrier in order to obtain payment for evaluation and/or treatment, and to document my child's evaluation results, treatment plan (if any), and diagnosis (as required by applicable contracts). I understand that payment or co-payment, if applicable, is due at the time of service, unless other arrangements have been made in advance.

The information in this consent form has been discussed with me. I have been given the opportunity to ask any questions I have regarding this consent. I am legally authorized to consent to the services provided by Elite Therapy for the above-named child patient.

Patient DOB	Patient Name	Today's Date

Parent or Guardian Name	Parent or Guardian Signature

ELITE
THERAPY

Attendance Policy and Agreement

Effective therapy requires a sustained commitment from providers and families. Without consistent contact between therapist and family, the outcomes of treatment for both parents and children suffer. With this in mind, our center strongly encourages both therapist and patient to keep all scheduled appointments, except in the rare case of emergency or illness.

Due to the high demand for the services provided and the need to accommodate those families who are on a waiting list;

- If **two consecutive sessions are missed**, Elite Therapy reserves the right to book additional patients in that scheduled time slot. Subsequently, absent patients will either be seen at a time determined by the company or placed on a waiting list (if no current time slots are available). Note- if more than one service is scheduled on the same day and only one provider is unavailable for any reason, patients are expected to keep their scheduled appointment with the other provider(s) on that date.

Initial___

- If **more than three sessions are missed during a six-month period**, the office manager and service provider will make a determination to continue services at Elite Therapy.

Initial____

- All cancellations must be made through the front office **24 hours** prior to the scheduled appointment time. (ph. 405-850-8497)

Initial___

- **If you fail to communicate any cancellation as listed above, Elite Therapy reserves the right to charge you $25 for a missed session.**

Initial___

- **If you reach $75 in unpaid fees, Elite Therapy reserves the right to determine termination of services.**

Initial____

We are committed to the growth, development, and long-term success of our patients. We look forward to a productive working relationship with you and your family.

_____
Patient Name

_____ _____
Responsible Party Date

_____ _____
Office Staff Date

ELITE
THERAPY

1505 Renaissance Boulevard,
Edmond, OK 73013
Phone: (405) 850-8497 Fax: (405) 300-0643

Severe Weather Closing Policy

All weather or incident-related announcements will be posted on our Facebook page and local news stations (if applicable).

The decision to cancel appointments or close our business will always be made before 6:00 a.m. Early closing will be communicated via an announcement on our Facebook page or text from the therapist.

It will be expected that all patients keep their appointments if Elite Therapy elects to remain open. Cancelled appointments will be tallied in accordance with our Attendance Policy. Decisions will be made based on safety of major streets, highways and interstates. Patients should assume we are open for business unless a cancellation notice is issued.

Elite Therapy will maintain normal hours of operation except under the following circumstances:

- Severe weather conditions that threaten the safety of patients and employees.
- Power outages that make it impossible to continue normal business.
- Other natural disasters or emergencies.
- In each of these instances, Elite Therapy Administration will determine if the situation is serious enough to warrant temporarily closing of the clinic.
- If a patient has a greater weather impact that makes attendance impossible- please contact the office to notify us.

Please like us on Facebook to get the latest updates, events, and educational postings. Thank you for your cooperation and we look forward to serving you and your family.

_____
Patient Name

_____ _____
Responsible Party Date

ELITE
THERAPY

Acknowledgment of Receipt of Notice of Privacy Practices

My signature below acknowledges my receipt of Elite Therapy's Notice of Privacy Practices.

Permission to:

		Yes	No
Leave a message on voice mail	**Please Initial**		
Leave a message with family member	**Please Initial**		
Receive text messages	**Please Initial**		
Email:_____@_____			

Today's Date:	Patient Date of Birth:
Patient Name (Please Print):	**Parent Signature:**

ELITE
THERAPY

Patient Name: _____

Patient DOB: _____

I authorize

ELITE THERAPY
1505 RENAISSANCE BLVD
EDMOND, OK 70313

To disclose and or obtain treatment information from the following:

Name: _____

Address: _____

Phone: _____

Email: _____

Please signature below if you agree to release ALL of your Protected Health Information.

If you are limiting the information that is released, please list ONLY the information you agree to be released: _____

By signing below I acknowledge that the above information about me may be released, discussed, or disclosed. I understand that my records are protected under Federal Regulations governing Confidentiality of Protected Health Information (PHI) under HIPAA and Confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2 and cannot be disclosed without my consent unless otherwise provided for the regulations. I also understand that I may revoke this authorization at any time and must do so in writing and present this written revocation to my therapist. I understand that once information is disclosed as per my authorization, the recipient, in accordance with eh applicable laws and regulations, may re-disclose the information and it might not be protected by federal or state privacy regulations.

Signature of Guardian: _____

Date Signed: _____

ELITE THERAPY

1505 Renaissance Boulevard,
Edmond, OK 73013
Phone: (405) 850-8497 Fax: (405) 300-0643

I, _____ hereby authorize Elite Therapy staff and/or therapists to take photographs and/or videos of my child, _____, for therapeutic and/or promotional purposes (such as company website, business page on Facebook, brochures, etc..) Your child's name or circumstances will NEVER be used in any way, to maintain you and your family's privacy. Our goal is only to personalize our promotional items to better connect with our families and those we hope to serve in the future. Thank you for your consideration.

_____ _____
Responsible Party Date

_____ _____
Office Staff Date

CYW Adverse Childhood Experiences Questionnaire (ACE-Q) Child

To be completed by Parent/Caregiver

Today's Date: _____

Child's Name: _____ *Date of birth:* _____

Your Name: _____ *Relationship to Child:* _____

Many children experience stressful life events that can affect their health and wellbeing. The results from this questionnaire will assist your child's therapist in assessing their health and determining guidance. *Please read the statements below. Count the number of statements that apply to your child and write the total number in the box provided.*

Please DO NOT mark or indicate which specific statements apply to your child.

1) Of the statements in Section 1, HOW MANY apply to your child? Write the total number in the box. ☐

Section 1. *At any point since your child was born...*

- Your child's parents or guardians were separated or divorced
- Your child lived with a household member who served time in jail or prison
- Your child lived with a household member who was depressed, mentally ill or attempted suicide
- Your child saw or heard household members hurt or threaten to hurt each other
- A household member swore at, insulted, humiliated, or put down your child in a way that scared your child OR a household member acted in a way that made your child afraid that s/he might be physically hurt
- Someone touched your child's private parts or asked your child to touch their private parts in a sexual way
- More than once, your child went without food, clothing, a place to live, or had no one to protect her/him
- Someone pushed, grabbed, slapped or threw something at your child OR your child was hit so hard that your child was injured or had marks
- Your child lived with someone who had a problem with drinking or using drugs
- Your child often felt unsupported, unloved and/or unprotected

2) Of the statements in Section 2, HOW MANY apply to your child? Write the total number in the box. ☐

Section 2. *At any point since your child was born...*

- Your child was in foster care
- Your child experienced harassment or bullying at school
- Your child lived with a parent or guardian who died
- Your child was separated from her/his primary caregiver through deportation or immigration
- Your child had a serious medical procedure or life threatening illness
- Your child often saw or heard violence in the neighborhood or in her/his school neighborhood
- Your child was often treated badly because of race, sexual orientation, place of birth, disability or religion