Today's Date: _____

Initial Intake Information

Family Tree Therapies
identify. understand. empower.

Client's Legal Name: _____

Client Preferred Name: _____

Date of Birth: _____ Age: _____

Current Gender Pronouns: _____ Sex Reflected on Insurance: _____

We recognize that the identities you carry might differ from legal and insurance identification.
In order to ensure that there are no errors with billing, please indicate the legal name on file with insurance.

if applicable, Parent/Guardian's Name(s): _____

Occupation(s): _____

Who are the members of your household?

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

Address: _____

City/State/Zip: _____

Phone: (H): _____ (W): _____ (C): _____

Email(s): _____

NOTE: *All appointment reminders will be sent via email.*

Employer of responsible party or insurance policy holder: _____

Address of employer: _____

Primary Physician: _____ Phone: _____

Associating Practice: _____

Insurance policy holder: _____

Relationship to client: _____ Policy holder's date of birth: _____

Primary Insurance: _____ Secondary Insurance: _____

if different than noted above, the address & contact information for the insurance policy holder:

Address: _____

City/State/Zip: _____

Phone: (H): _____ (W): _____ (C): _____

Place of employment: _____

Address of employer: _____

Primary concerns/reasons for visit and/or goals for therapy:

Any medical diagnosis?

_____

How did you hear about our office? _____

Please continue on to the consent form (attached). Thank you.

Initial Intake Consent Form

Photography & Recording Consent:

I understand that this form will reflect my wishes regarding photographs and/or recordings (audio or video) of Family Tree Therapies' client, _____ *(print client's full name).*

Please initial any statement(s) that apply:

_____ I understand that these photographs and/or recordings are for ***clinician use***. They will be used for the purpose of treatment planning, evaluation, and to provide feedback. The materials may be viewed by the therapists at Family Tree Therapies for mentoring or teaching situations.

_____ I understand that these photographs and/or recordings may be used in any ***promotional materials*** for Family Tree Therapies. These may include flyers, brochures, social media, and/or community promotion.

Please choose and initial *one* of the sentences below:

_____ My questions have been answered to my satisfaction, and **I agree** to participate in these recordings.

_____ My questions have been answered to my satisfaction, and I agree to allow participate in these recordings, **with the following exceptions**:

_____ My questions have been answered to my satisfaction, but **I do not wish** to participate in these recordings.

Notice of Privacy Practices:

_____ I acknowledge that I am able to request an immediate copy of Family Tree Therapies' privacy policy at any time.

Consent to Treatment:

_____ I affirm that I have willingly sought therapy through Family Tree Therapies. I agree and consent to therapy treatment from Speech and Voice Solutions and/or TheraPlay at this time.

_____ I understand that it is my choice to bring any other individuals to my session(s), and if I allow these individuals outside of Family Tree Therapies' staff to be present during the session then confidentiality may not be guaranteed during that time.

By signing below, I am hereby stating that my above choices as the client, or as legal parent/ guardian of the client, accurately reflect my wishes. I agree that my electronic signature is the legal equivalent of my manual signature on this and all other Family Tree Therapies forms.

Signature of client or legal guardian | Printed Name | Date

Please continue on to the information & communication release form (attached). Thank you.

Information & Communication Release Form

In accord with my legal right to confidentiality and privileged communication relevant to the services being received at Family Tree Therapies, I authorize and request the disclosure of confidential information outlined below. I acknowledge that this release is voluntary and may be voided or edited at any time. *This release is in addition to any individuals of legal age listed under "household members" on the client's initial intake information form.*

This release form requests an exchange of information regarding _____
(client's full name and DOB)

From: Family Tree Therapies, 2251 East Paris Ave SE / Grand Rapids MI / 49546.
Family Tree Therapies, 570 E Division Street NE/ Rockford MI / 49341

if applicable, Family Tree staff member(s): _____

Name:		*Name:*	
Facility, if applicable:		*Facility, if applicable:*	
Relationship to client:		*Relationship to client:*	
Address:		*Address:*	
Phone:		*Phone:*	
Email:		*Email:*	

Communication is requested regarding (check all that apply):

- ☐ Speech-language therapy
- ☐ Occupational therapy
- ☐ Records or documentation of therapy
- ☐ Verbal exchange of information
- ☐ Other

For the purpose of (check all that apply):

- ☐ Continuing care
- ☐ At my request
- ☐ Notifying child's doctor
- ☐ Other

I authorize that Family Tree Therapies may release information regarding services provided to this client to the following individuals:

This release will expire on: _____

Signature of client or legal guardian Printed Name Date

Please continue on to the financial policy & agreement (attached). Thank you.

1. This release may be withdrawn in writing at any time, unless action has already been taken, based on this content.
2. The information release with this authorization is confidential. If this information is given to a person/agency that is not required to meet State Law (Michigan Mental Health Code) or Federal laws (HIPAA), that person/agency may choose to disclose the information to another party.
3. This authorization is based on the Michigan Mental Health Code (P.A. 258 of 1996, Section 748; P.A. 152 of 1996) and HIPAA (45 CFR parts 160 and 42 CFR 2.31).

Family Tree Therapies' Financial Policy

We are open to discussing fees and financial policies with you at any time. Your clear understanding of our financial policies is very important to our therapeutic and professional relationship.

Payments & Insurance:

- Private pay clients will need to pay our office for the services at the time of your appointment. If our office is billing your in-network insurance policy, any anticipated member liability will be due at the time of service.
- The adult accompanying a minor at the time of service is responsible for full payment. For unaccompanied minors, the parents or guardians are responsible for full payment. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit card, or paid by check or cash at the time of service.
- We accept cash, check, Visa, Master Card, Discover, and American Express.
- **Family Tree Therapies is an entity that encompasses multiple businesses**. Your payments must be made to the specific business that provided the service. Your credit card receipts will reflect this. For services provided by a speech therapist, make your payment to **Speech and Voice Solutions**. For services provided by an occupational therapist make your payment to **TheraPlay, Inc**.
- Both Speech and Voice Solutions & TheraPlay are in-network providers with **Blue Cross Blue Shield** *(please note this does not include Blue Care Network)*, **Priority Health**, **Aetna**, **Cofinity**, **Cigna**, **ASR** and **Medicare**. We will work with you and your doctor to submit an insurance claim if you are a member of one of these insurance companies.
- If necessary, Family Tree will promptly reimburse you any funds that were covered by insurance that exceed the anticipated collected rate at the time of service.
- Insurance is a contract between you and your insurance company. Reimbursement through out of network insurance companies will be your responsibility.

Please read and initial each line:

_____ It is your responsibility to notify Family Tree Therapies of any changes in your insurance plan(s).

_____ Knowledge of coverage benefits, limitations, and/or exclusions of your insurance plan is your responsibility through direct communication with your employer and/or insurance carrier(s). Grievances regarding coverage would need to be filed with your insurance company, by the policy holder.

_____ We highly recommend that the member contact their insurance company to fully understand their benefits - including deductibles, copays, exclusions, and allowed number of therapy visits.

_____ Family Tree Therapies is not responsible for tracking your visit count or reporting to you the number of visits used to date. We may assist you in tracking your visits by providing a summary of sessions performed, when requested to do so.

_____ Our office may place a courtesy call to your insurance company to inquire about benefits, however this is not a guarantee of coverage. You are ultimately responsible for your bill, and our office is not liable for what your insurance company predicts coverage to be. Family Tree Therapies will do their best to explain potential coverage, but is ultimately not responsible to be aware of all specific conditions/limitations related to your individual insurance policy.

_____ Members of any insurance company are financially responsible for any deductibles, co-pays, non-covered, or denied services determined by their insurance company.

_____ If you accumulate 5 consecutive unpaid dates of service that have not been processed/paid by insurance, your account will be switched to a private pay account until insurance has made a determination. Once insurance processes past dates of service, any overpayments you have made will be promptly reimbursed.

_____ Family Tree Therapies does not give medical advice and does not encourage changing of any medication regime cleared by the prescribing doctor.In order to bill your medical insurance, we will need a prescription for therapy from your pediatrician, dentist, psychiatrist or other physician. Our therapists will make recommendations for ICD-10 diagnostic codes and will send a prescription request to your PCP on file. If your PCP does not sign, we will not be able to bill your insurance and your account will be switched to private pay and you will be required to pay for all services received.

Additional Fees & Information:

- Appointments missed without a 24 hour advanced notice will be assessed a $50 no show fee.
- After 50% missed appointments in a two-month period and/or three (3) consecutively missed appointments, you will lose your regularly scheduled slot. At this time you may call our office on a weekly basis to schedule during any available spots.
- Balances not paid within 120 days will be sent to collections and will receive a 35% collection fee.
- Checks returned due to insufficient funds will be assessed a $35 fee, to cover bank charges.
- A $65 fee will be charged for records and/or reports requested by out of network insurance companies that are above and beyond normally requested billing information.
- A $25 fee will be charged for extensive records and/or reports requested by your doctor or educational system. No records/reports will be released nor materials loaned without payment in full on all balances.
- The total number of sessions (occupational & speech therapy combined) will not exceed 12 45-minute time slots (9 total therapy hours) per week. A week is defined as Monday through Friday.

I have read and understand the above information. I understand that I am responsible to pay for service rendered, including reasonable costs of collections and attorney's fees in the event of default.

Signature of client or legal guardian | Printed Name | Date

Family Tree Therapies' Financial Agreement

This agreement is considered to be an extension of Family Tree Therapies' Financial Policy.

Out of network / private pay clients fill out this box only:

I acknowledge that my insurance company does ***not*** participate with either business (Speech and Voice Solutions, LLC and/or TheraPlay, Inc.) at Family Tree Therapies. I am responsible for full payment at the time of services, at the private pay discounted rate. I am responsible for any additional fees as outlined in Family Tree Therapies' financial policy.

Initial here: _____ Payments made on day of service will qualify for a prompt pay discount of $30, for a total of $120 per 45 minute treatment session. Payments made 24 hours or more after date of service will be charged $150 per 45 minute treatment session. 90 minute evaluations are $250.

_____

Signature of client or legal guardian | Printed Name | Date

…or continue on & choose one of the following boxes to complete:

I am a current member of the Blue Cross Blue Shield (BCBS), Priority Health, Aetna, Cofinity, Cigna, ASR, and/or Medicare insurance company.

Family Tree Therapies is considered to be a participating provider for these insurance payers. This title does ***not*** extend to Blue Care Network, for which they are considered non-participating. For my appointments, payment is expected at the time of services. At this point I will decide on *one* of the following two options:

◯ *(check here if the following option is your final decision - initial and sign this section only)*

I choose to have Family Tree Therapies **submit a claim** to my insurance company for my appointment. A prescription will be provided for approval by the patient's doctor, and Family Tree Therapies must receive a signed copy of this prescription before submitting a claim to insurance.

Initial here: _____ I understand I am ultimately responsible for my bill, should my insurance company not pay one of my claims for any reason.

I acknowledge that if this claim is applied toward my deductible, I am responsible for full payment of the amount applied to my deductible, which is determined by my insurance company. Deductibles and coverage policies vary by individual plans, so questions should be directed to an insurance representative. If necessary, Family Tree will promptly reimburse any funds that were covered by insurance.

_____

Signature of client or legal guardian | Printed Name | Date

◯ *(check here if the following option is your final decision - initial and sign this section only)*

I choose to remain a private pay client. I ***refuse*** to have Speech and Voice Solutions, LLC or TheraPlay, Inc. submit a claim on my behalf to my insurance company. I understand that my sessions will not be applied toward any deductible I might have, and I will be responsible for the private pay rate described above. I acknowledge that I will not be able to send my insurance company invoices myself for potential in-network coverage, for future or past visits. Should I decide to have either business submit an insurance claim on my behalf in the future, they will require an updated and authorized Financial Agreement, and will not be able to bill back for past sessions.

_____

Signature of client or legal guardian | Printed Name | Date

Family Tree Therapies
identify. understand. empower.

Speech and Voice Solutions, LLC
TheraPlay, Inc.

2251 East Paris Ave SE
Grand Rapids, MI 49546

570 E Division St NE
Rockford, MI 49341

CREDIT CARD OR BANK DEBIT AUTHORIZATION FORM

Please complete all fields.
You may cancel this authorization at any time by contacting us.
This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____ CVC: _____ zip code _____
Bank Debit Information
Account Type _____Checking _____Savings
Routing number _____
Account number _____

I,_____, authorize Family Tree Therapies to charge my credit card/bank debit account above for any copays, co-insurance, deductible payments and or private pay payments. I understand that my information will be saved on file for future transactions on my account. This authorization will remain in effect until the expiration date on the card or until I communicate my intention to cancel by calling Family Tree Therapies at 616-447-7799.

_____

Client Signature: Date: