engage therapy center

10263 Chicago Drive,
Zeeland, MI 49464

Adult Occupational Therapy Intake Form

Client Information:

Name____ Preferred Name _______________________

Birthdate ____________________Male ___Female___ Pro-noun (Optional) _________________

Address ____

Home/Cell Phone Number __________________________/__________________________________

Email____

Emergency Contact Information:

Name ____ Relationship _______________________

Phone Number ______________________________

Primary Care Physician Info:

Primary Care Physician Name: ____

Practice Name: ____

Address: ____

Phone Number: ______________________________ Fax Number: _____________________________

Referral Information:

Referred by____

Reason for referral ____

Medical Information:

Current concerns/diagnosis (provided by a health care professional) _________________________

____

____

____

____

____

Area(s) of pain/intensity (scale of 0-10) ____

____

____

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Previous medical concerns (i.e. surgeries, injuries, hospitalizations) ________________________
____
____

Current prescribed medications____
____

Medical precautions____

Other health care services you are receiving currently (Psychologist/therapist, PT, Speech, Nutritionist, Chiropractor, other) ____
____
____

How are current concerns impacting your daily activities/leisure__________________________
____
____

Goals for therapy____
____
____
____
____

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Financial Policy and Fee Agreement

Please review our financial policy and fee agreement which describes our schedule of fees for service, policies regarding charges not covered by insurance, and additional fees. Please be sure that you understand the financial agreements regarding insurance reimbursement, methods of payment, and dues regarding cancelations, missed appointments, and past due accounts. If you have any questions or concerns about your individual policy and its coverage, please speak directly with your provider prior to signing this agreement.
Invoices are generally sent out weekly via email.
Payment is expected at time of service or within one week of received invoice.

Cost:
Evaluations - $160
55-minute treatment sessions - $135
30-minute treatment sessions (pre-approval required) - $75

Missed Appointments or Late Cancelation Policy:
Missed appointments or cancelations without a 24-hour notice may be assessed up to $75.
In addition, clients who accumulate excessive cancellations or missed appointments may lose preferred time slots and in extreme cases may be removed from the schedule.

Additional Fees:
Checks returned due to non-sufficient funds will be assessed a $20 fee
Past due accounts over 30 days may be assessed an extra $25 per month fee

Insurance Reimbursement:
Engage Therapy Center accepts and processes payments through a variety of insurance providers. Currently we work with Blue Cross Blue Shield, Anthem, Priority Health, and Cigna. Coverage is based on diagnosis, procedure codes, referring provider, and insurance plan. It is recommended that individuals contact their individual providers to fully understand their benefits, including deductibles, co-pays, exclusions, and allowed number of therapy visits. As insurance is a contract between you and your insurance company, Engage Therapy is not liable for gaps in coverage, lack of coverage or other insurance denials or disputes.

Obligation of payment is understood not to be dependent on the client receiving third party reimbursement from outside insurance coverage. We support and encourage our clients to pursue the maximum amount of financial reimbursement from third party payers, such as health insurance agencies. Ultimately, it is the client’s responsibility to submit and secure coverage that falls outside of Engage’s partnered insurance companies. Private pay documentation differs from standard documentation, therefore, it is necessary to alert your therapist before the evaluation if you will be pursuing third party reimbursement.

Insurance Coverage and Billing:
I have read and accept Engage Therapy's financial policy and I agree to (1) allow Engage Therapy Center to bill my insurance directly for services provided; (2) give Engage Therapy Center permission to release information about me that the insurance company may require in order to process payment; (3) assist with the claims process as required by Engage Therapy Center or my insurance provider; (4) allow Engage Therapy Center to communicate billing information to the insurance holder.
I understand that if my insurance plan requires a deductible amount prior to coverage, I will be responsible for the full session fee until the required deductible amount has been met**.**
I understand that it is my responsibility to notify Engage Therapy Center if my insurance plan/coverage changes**.**

Insurance Information
Primary Insurance: ____
Insurance policy holder: __________________________DOB______________________________
Relationship to client: ____

Address and contact information if different than client's primary residence:
Address: ____
City/State/Zip: ____
Phone: (H)________________________(W)_____________________(C)______________________

Email address to send invoices to:
____

Patient Name (printed) ____

Patient/Guardian signature____

or

Private/Self-payment for Services
I have read and accept Engage Therapy's financial policy and I agree that I will self-pay for services at Engage Therapy Center. I agree to the fee schedule outlined in this document. I understand that payment for services is due at the time services are provided.

Patient Name (printed) ____

Patient/Guardian signature____

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Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Engage Therapy Center to use and disclose protected health information (PHI) to carry out treatment, payment and health care operations, and communicate to other health care providers and schools.

The Notice of Privacy Practices provided by Engage Therapy Center more fully describes such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this contract. I acknowledge that this release is voluntary and may be voided or edited at any time. I have the right to request that Engage Therapy Center restrict how it uses or discloses PHI.

With this consent, Engage Therapy Center may call my home or alternate location and leave a message regarding appointments or insurance/payment questions.

With this consent, Engage Therapy Center may mail any items that assist the plan of care, such as appointment reminders and patient statements, as long as they are marked "Personal and Confidential." Additionally, Engage Therapy Center may email me information, such as appointment reminders and patient statements.

By signing this consent, I give permission for Engage Therapy Center to communicate information about the treatment session with relatives and adults bringing me to my appointment.
These individuals are not to receive information: ____
____

Client's name: ____
Signature: ____
Date: ____

Specific providers I would like Engage Therapy Center to release information to if requested:

Name of provider: ____
Facility: ____ Phone: _________________________

Name of provider: ____
Facility: ____ Phone: _________________________

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Photography and Recording Consent

☐ I agree to photos/videos being taken for clinician use. They will be used for the purpose of evaluation, planning, and mentoring. The materials will only be viewed by Engage Therapy therapists and fieldwork students.

☐ I agree to photos/videos being used for promotional materials for Engage Therapy Center. This may include social media, flyers, or brochures. I will be shown materials for approval before publication.

Signature of Client or Legal Guardian: ____