ARKANSAS THERAPY OUTREACH

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AUTISM CLINIC reach

For Office Use Only
Date Received: _____
Date of Intake: _____ N/A
Rx Due Date: _____

New Referral Intake Form

Please Indicate Therapy Services Requested:

- ☐ Developmental Therapy Evaluation
- ☐ Speech-Language Evaluation
- ☐ Occupational Therapy Evaluation
- ☐ Physical Therapy Evaluation
- ☐ Autism Evaluation: R.E.A.C.H. Program
- ☐ Mental Health Therapy Services
- ☐ Applied Behavior Analysis (ABA)
- ☐ Other: _____

Child's Name: _____ Child's Date of Birth: _____
First Middle Last

Male_____ Female_____ Social Security #: _____ Current/Previous Therapy: _____

Facility Your Child Attends (daycare/pre-school/etc.): _____ City: _____

Legal Guardian (s): _____ Relationship to Child: _____

Address: _____
Street Apt. # City, State Zip Code

Primary Phone #: _____ Name: _____ May we leave a voicemail: _____

Secondary Phone #: _____ Name: _____ May we leave a voicemail: _____

Email Address(s) *Required for invoices and service details: _____

Name of Primary Care Physician used for well-child visits: _____

Clinic Name: _____ City: _____ Phone: _____

FUNDING INFORMATION

Please select all that apply:

☐ My child has Medicaid, ARKids First or TEFRA Coverage ***Number:** _____

☐ My Child has Health Insurance Coverage ***MUST ATTACH A FRONT AND BACK COPY OF CARD***

Policy Holder FULL Name: _____ Date of Birth: _____

☐ My Child does not have Medicaid or insurance benefits. Please call! We welcome the opportunity to help your child!

AUTHORIZATION FOR SERVICES TO BE PROVIDED BY ATO

1) I hereby authorize Arkansas Therapy Outreach, LLC (ATO) to provide the indicated therapy evaluation and treatment services, if warranted by evaluation recommendations, to my child according to the recommended Plan of Care (POC).
2) I hereby authorize ATO to release any medical information acquired in the course of my child's examination or treatment to my child's health and hospital insurance carriers to facilitate payment for medical services rendered. I also authorize ATO to provide referral information including contact information and referral details to state agencies as required.
3) I authorize ATO to use my email address listed above to communicate protected health information with me personally as needed including statements/invoices, evaluation results, plan of care and/or appointment scheduling information.
4) I have received and reviewed a copy of ATO's Privacy Policy.
5) I have reviewed ATO's Fee Schedule. I agree to pay co-payments, insurance fees or non-covered benefit fees to ATO once invoices are received. I agree to inform ATO, in a timely manner, when there is a change in my child's health benefit plan or primary care physician. I further agree to reimburse ATO for any costs incurred for denial of therapy services should I disregard this policy.
6) I request and authorize payment of benefits to ATO. I authorize payment of medical benefits to ATO and each individual provider associated with the care and treatment of my child. I understand that giving consent for the above-mentioned purposes is voluntary and can be revoked at any time.
As the parent or legal guardian of this child I have read the above information. I understand and accept all terms and conditions.

_____ _____
Signature of Parent/Legal Guardian Date

Please complete back page also & return directly to ATO at your earliest convenience.
We are unable to serve your child without this intake information. Thank you!

Arkansas Therapy Outreach

Developmental History – Short Form

Informant Name: _____ Relationship to Child: _____

Child's Name: _____ Sex: Male / Female **Date of Birth:** _____/_____/_____

MEDICAL HISTORY

Current Diagnoses: _____ Current Meds: _____
Hospitalizations/Major Illnesses/Surgeries: _____

FAMILY HISTORY

Child lives with: Mother Father Stepmother Stepfather Guardian Other: _____
Is there any history of learning, neurological, psychological or hereditary problems in the immediate family or mother/father's families?
If so, please describe: _____

PREGNANCY / BIRTH HISTORY (ONLY COMPLETE IF CHILD IS 0-5)

Complications during Pregnancy: _____
Complications at birth or infancy: _____
Child adopted? Yes / No Gestational Age (how many weeks was the child carried): _____ Birth Weight: ____ lbs. ____ oz.

STATEMENT OF CONCERN & DEVELOPMENTAL HISTORY

What are your primary concerns for your child? _____
_____
_____
What languages does your child speak? _____ What is the *primary* language? _____
Did your child struggle to achieve developmental milestones in any areas (communication, motor skills, social skills, feeding, etc.)? If so, please explain and provide age when skills were acquired:_____
_____

Please indicate all areas of current concern for your child:

	Speech errors / unclear speech		Stuttering / fluency of speech		Social skills / communicating with peers
	Vision:		Hearing:		Swallowing / choking
	Feeding / limited diet / texture aversion		Sensory processing		Behavior / mental health
	Reading		Handwriting		Listening / following directions
	Sitting up / rolling over / crawling		Walking / Running		Uncoordinated / clumsy
	Climbing stairs		Dressing / undressing		Toilet training / daily living activities
	Lack of speech production / vocabulary		Other:		

How did you hear about ATO or who referred you for our services? _____

PREVIOUS THERAPY / SERVICES & CURRENT PLACEMENT

Has your child ever been examined by the following professionals? If so, **submit a copy of all reports** (required).
____ Speech-Language Therapist Provider: _____ Last Date of Service: _____
____ Occupational Therapist Provider: _____ Last Date of Service: _____
____ Physical Therapist Provider: _____ Last Date of Service: _____
____ Psychologist / Mental Health Provider: _____ Last Date of Service: _____
____ Otolaryngolost (ENT) Provider: _____ Last Date of Service: _____
Child care program or school your child attends: _____ City: _____
Days and times your child is available to be seen: _____

Please review the following timelines and tips to better understand the process required for therapy services:
1) A Care/Service Coordinator will contact you to confirm receipt, answer any questions and address funding for testing / therapy.
2) We will request a referral prescription which is required for evaluations or treatment prescription which is required for therapy.
3) A therapist will contact your family for scheduling once the prescription is received. If your child is in need of more than one type of evaluation (speech, occupational, physical, developmental, etc.), you will speak with each therapist prior to the evaluation.

Please contact our office to speak with a Care/Service Coordinator at any time during the process. We are very happy to help!