(THIS BOX IS FOR OFFICE USE ONLY)

DX CODES~FOR VERIFICATION: _____

NEW PATIENT INTAKE FORM

Blue Sky Therapeutics, LLC

PATIENT INFORMATION

(PLEASE PRINT CLEARLY)

Name:_____ Age:_____ DOB_____/_____/_____ Sex: M / F

Street address: _____

City:_____ State:_____ Zip:_____

Home Phone: ( )_____-_____ Emer. con. Ph: ( )_____-_____

Emergency contact name: _____

Chief complaint (specific reason for your visit):_____

_____

*RESPONSIBLE PARTY INFORMATION *PLEASE READ: If the patient is a minor, and his/her parents are separated, we will only bill one party, but both parties must sign the attached financial agreement.*

Name:_____ DOB_____/_____/_____ Sex: M / F

Street address to send billing:_____

City:_____ State:_____ Zip:_____

Hm. ph.:( )_____-_____ Wk:( )_____-_____ Mob:( )_____-_____

Email address:_____

S.S.#_____-_____-_____ Marital status:_____ Relation to patient:_____

Employer:_____ Empl. Ph:( )_____-_____

INSURANCE INFORMATION *(Please enter hand written information, as well as presenting your ins. card)*

Primary insurance:_____ Ph # for Mental Health:( )_____-_____

Subscriber name:_____ SS #_____-_____-_____ DOB:_____/_____/_____

Relation to Client:_____ ID/Membership #_____ Group # _____

Secondary insurance: _____Ph # for Mental Health:( )_____-_____

Subscriber name:_____ SS #_____-_____-_____ DOB:_____/_____/_____

Relation to Client:_____ ID/Membership #_____ Group # _____

I hereby authorize Blue Sky Therapeutics, LLC to release any information, requested by the above-named insurance companies, that is needed to process claims, and to pay directly to Blue Sky Therapeutics, LLC, any insurance benefits. I hereby authorize Blue Sky Therapeutics, LLC, to release any information requested by *LeDon Medical Billing*, which is needed to bill the above-named insurance co. and/or responsible party directly. In addition, I also authorize Blue Sky Therapeutics, LLC and *LeDon Medical Billing* to send clinical or billing communications via my email address, if I have provided it on this New Intake Form. I affirm the above information to be true and correct, and give my consent for treatment. I understand that I am entitled to a copy of this agreement.

Signature_____ Date: _____/_____/_____

PATIENT/ GUARANTOR FINANCIAL AGREEMENT
Blue Sky Therapeutics, LLC
(Ledon Medical Billing)

INSURANCE COVERAGE AND BENEFIT INFORMATION-

If you would like information about your estimated financial obligation, related to insurance, for services, please contact my billing agent, LeDon Medical Billing 801-756-7200. As a courtesy to you, my billing service will verify your insurance coverage and benefits. However, I encourage you to call your insurance company, and re-verify your coverage and benefits. Please be aware that verification of insurance coverage and benefits, is not a guarantee of insurance payment, and coverage/benefits are *frequently* quoted incorrectly. Keep in mind that some procedures will not be covered at all, even if your insurance company has quoted coverage for those procedures. You will be responsible for payment in full if your insurance company does not pay, *or*, if your insurance company does not pay in a timely manner. All patients, who are required to seek reimbursement for my services through their insurance company, will be expected to pay for services in full when appropriate (deductible) at the time of service, unless prior arrangements are made. My billing service will then submit claims on your behalf, so that you may be reimbursed by your insurance company. However, this is not a guarantee that your insurance company will reimburse you as they quoted. If your account should need to go to collections or attorneys hired, you agree to pay any collection expenses or actual attorney fees for Blue Sky Therapeutics, LLC.

PLEASE CONTACT BLUE SKY THERAPEUTICS FOR OUT OF POCKET RATES

ACCEPTANCE OF TERMS OF FINANCIAL RESPONSIBILITY-

(Please read the following financial terms and conditions carefully, and if you agree, please sign and date each one. Thank you!)

1.) MISSED APPOINTMENTS:

I (the undersigned) understand that if I will not be able to come to an appointment, I am required to give notice prior to appointment time. In the event that I do not give said notice, I specifically agree to pay a fee for the missed appointment in the amount of $25.00. I understand that it is my financial obligation to pay this fee within two weeks of the missed appointment date. I understand that by signing below, I agree to the terms and conditions listed above.

_____ _____
Signature Date

2.) RETURNED CHECKS:

I (the undersigned) understand that in the event that there is a returned check, I specifically agree to pay a $25.00 returned-check fee, in addition to the original payment amount, due within 2 weeks of the original payment date. I understand that by signing below, I agree to the terms and conditions listed above.

_____ _____
Signature Date

3.) RECOVERY OF INCURRED CHARGES:

I (the undersigned), understand that once my account is 30 days late, I will pay a **5%** monthly finance charge. I understand that this charge is a billing service charge, and cannot be removed once it has been applied. I also understand that if my account reaches 90 days past due, it may be immediately turned over to a collection agency. If the account is referred to a collection agency or attorney for collection, I further agree to pay an additional amount representing fifty percent (60%) of the principal balance. This additional amount is in recognition of the costs associated with said collection action processing. In the event legal action is taken to collect on the account, I also specifically agree to pay all reasonable attorney's fees and court costs. I understand that by signing below, I agree to the terms and conditions listed above.

_____ _____
Signature Date

Consent to Treat/Evaluate Form

The patient and/or legal guardian authorizes the Occupational Therapist to examine and treat the condition as he/she deems appropriate through the use of occupational therapy measures, and the patient and/or legal guardian gives the authorization for these procedures to be performed. The patient and/or legal guardian has the right to be informed and participate in decisions involving his/her child's health care. This shall be based on clear, concise explanation of his/her condition and of all proposed treatment procedures. All possible risks and/or side effects as well as the probability of success with such procedures shall be disclosed to the patient and/or legal guardian by his/her attending Occupational Therapist. The patient and/or legal guardian will not hold the Occupational Therapist responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. The patient and/or legal guardian has the right to know who is responsible for authorizing and performing any and all treatment procedures. The patient shall not be subjected to any procedure without his/her voluntary, competent, and understanding consent or the consent of his/her legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall be so informed. Updates on goals and sessions will be provided on an as needed basis. Review of medical records may be subject to a fee. Out of session consultation and time will also be subject to a fee.

After reading the above (or having it read to me), I hereby consent (or give consent for my child) to receive occupational therapy services from Blue Sky Therapeutics, LLC I have read (or have had read to me) the above information and understand the content.

Patient/Guardian Signature_____ Date_____

Blue Sky Therapeutics Representative _____ Date_____