Aspen Center
planting roots for development

Intake Packet Checklist

Client Name: _____ Date of Birth: _____

Email: _____

Physician: _____ Phone #: _____

Case Coordinator: _____ Ext: _____

Therapist: _____

- ☐ Privacy Statement (HIPPA)
- ☐ Consent to Evaluate/Treat
- ☐ Consent to File
- ☐ Authorization to Release Information
- ☐ Release to CDSA
- ☐ Acknowledgement of receipt of Privacy Practices
- ☐ Insurance information and photo copy of insurance card and drivers license
- ☐ Acknowledgement of receipt of Fee Collection Policy (if applicable)

Client Name: _____ DOB: _____

Privacy Statement (HIPPA)

NOTICE
The Aspen Center, Inc. is required by law to keep your health information confidential. The Aspen Center, Inc. is required to keep your health information on site for 7 years. After which they will be shredded. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

YOU'RE RIGHTS
This is a statement of your client Rights regarding the release of your client information. Treatment will not be conditioned on signing this Authorization form. Information from your client record is only released with your written permission. (The exception to this policy is requests that are court ordered)

This authorization may be revoked at any time. The revocation must be in writing, signed by you and delivered to:

The Aspen Center, Inc. at 3700 Fox Stone Dr. Raleigh, NC 27603. The revocation will take effect when The Aspen Center, Inc. receives it.

You are entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION
Unless otherwise revoked, this Authorization expires when the earliest of the following occurs; one year from the original date, or when he/she is discharged by The Aspen Center, Inc.

_____ _____
Signature of parent/legal guardian **Date**

_____ _____
Signature of Witness **Date**

Client Name: _____ DOB: _____

Consent To Evaluate/Treat

I _____ hereby authorize The Aspen Center, Inc. to
(Name of Parent or Legal Guardian)

Evaluate/Treat: _____.
(Name of Child)

I understand that the results of the evaluation will be returned to the Parent/Legal Guardian, Physician referring the Child. I authorize The Aspen Center, Inc. to release information, electronic or paper, about my child as necessary to process claims for payment for services rendered, including health insurance companies; agencies processing Medicaid; medical benefits plans, case managers or reviewers; or third parties responsible for paying claims for services provided to my child. I authorize payment for those services to be made directly to the provider or practice.

I authorize The Aspen Center, Inc. to communicate with other service agencies and providers in order to provide support and guidance regarding my child's development, as well as to receive consultation from other service providers in order to enhance service delivery.

If child is part of ITP/Raleigh CDSA
I understand that The Aspen Center, Inc. must be an authorized service on the IFSP (if child is part of CDSA). I further understand that I will be billed at the ITP current sliding fee scale rate (which my service coordinator will assist in determining).

I understand that if I have Medicaid and/or Insurance, The Aspen Center, Inc. will bill Medicaid and/or Insurance for all therapies provided.

I understand that The Aspen Center, Inc. will disclose information to other service agencies and providers (to include but not limited to: the Children's Developmental Services Agency (CDSA)) for program planning (IFSP's) and for billing purposes.

I will contact The Aspen Center, Inc. if I need to make any changes in scheduled sessions and expect my therapist to do the same. If I do not contact my therapist, but fail to follow through with the scheduled appointment, it will be considered a 'no show'. After 3 consecutive (or 5 non-consecutive) 'no-shows' I understand that The Aspen Center, Inc. may choose to discontinue services.

_____ _____
Signature of parent/legal guardian **Date**

_____ _____
Signature of Witness **Date**

Client Name: _____ DOB: _____

Consent to File

I _____ hereby authorize The Aspen Center, Inc. to file claims to my
(Name of Parent/Legal Guardian)
insurance and/or Medicaid for the Evaluation and/or Treatment of: _____
(Name of Child)

I authorize The Aspen Center, Inc. to release information, electronic or paper, about my child as necessary to process claims for payment for services rendered, including health insurance companies; agencies processing Medicaid; medical benefits plans, case managers or reviewers; or third parties responsible for paying claims for services provided to my child. I authorize payment for those services to be made directly to the provider or practice.

I also understand that if I have a co-pay or a deductible to meet, I will make payment to The Aspen Center, Inc. upon receiving an invoice for evaluation/treatment; which may contain multiple treatment dates.

The Aspen Center, Inc. will send claims to the insurance company and wait for reimbursement. It will then file any secondary insurance, if any, Medicaid, if applicable, and/or file a claim for reimbursement from Infant Toddler Program. This may take up to 60 days. The Aspen Center, Inc. will then bill client any remaining balance due, if applicable. We accept cash, personal checks, Visa, and Mastercard. There is a return check fee. If you have not paid in full or arranged payment plan within 120 days, we will refer your account to a collection agency.

By signing this form, it indicates that I have **read** and **fully understand** the terms listed above. This document has also been **explained** to me, and I fully understand all terms and responsibilities.

_____ _____
Signature of parent/legal guardian **Date**

_____ _____
Signature of Witness **Date**

Client Name: _____ DOB: _____

MEDICAID INFORMATION

CLIENT'S NAME EXACTLY AS IT APPEARS ON HIS/HER MEDICAID CARD INCLUDING MIDDLE INITIAL.

FIRST _____

MIDDLE _____

LAST _____

MEDICAID NUMBER EXACTLY AS IT APPEARS ON THE CLIENT'S CARD.

The Medicaid number will only be used by The Aspen Center, Inc. staff for billing purposes

_____ _____
Signature of parent/legal guardian **Date**

_____ _____
Signature of Witness **Date**

In order to file your insurance we need the following:

Child's Name: _____ DOB: _____

Subscriber: _____ Subscriber's DOB: _____

Address: _____

Photo Copy Insurance card and Parent/Legal Guardian's Drivers License below or on back:

Office Use Only:
Copy of Insurance card obtained: ___ CDSA? ___ ICD9: ___

Client Name: _____ DOB: _____

Authorization to Release Information

I, _____ (parent/guardian)

Hereby authorize The Aspen Center, Inc. to disclose specific health information from records of the above named client to:

Children's Developmental Services Agency
Chapanoke Rd
Raleigh, NC 27699

Phone number: 919-662-4600 Fax number: 919-662-7337

For the following purposes: Maintain Client Records

SPECIFIC INFORMATION TO BE DISCLOSED

- Health and medical records
- Social/developmental history
- Physical therapy evaluations
- Occupational therapy evaluations
- Speech/language evaluations
- Developmental assessments
- Nutritional assessments
- Educational evaluations
- Psychological evaluations
- Multidisciplinary evaluations
- Individualized family service plans
- Treatment plans
- Progress notes/reports

_____ _____
Signature of parent/legal guardian **Date**

_____ _____
Signature of Witness **Date**

Client Name: _____ DOB: _____

Authorization to Release Information

I, _____ (parent/guardian)

Hereby authorize The Aspen Center, Inc. to release/receive information regarding the above named client to the following agencies/facilities:

1. _____
2. _____
3. _____

The purpose of this information is needed for continuity of care

I hereby release, discharge and agree to hold harmless all parties to whom this consent is given from any liability that may arise from the release of information

I understand that I may revoke this consent at any time, excluding any information that has already been released. Without my expressed revocation, this consent will expire:
(A**uthorization cannot exceed one year from the date of signature**)
I understand the release of my medical information may include transferring copies of my medical records by mail, phone, or facsimile (FAX) machine. It is understood that faxing represents transfer of information by using electronic equipment and the potential for error increases when complicated pieces of equipment are involved. It is understood that this tpe of information transfer includes the possibility that records may arrive at a destination other than the intended destination.

Specific Information Being Released includes:

___ Speech/Language Evaluations
___ Speech/Language Progress notes
___ Occupational Therapy Progress notes
___ Summaries
___ Other _____
___ Speech/Language Discharge
___ Occupational Therapy Evaluation
___ Occupational Therapy Discharge

_____ _____
Signature of parent/legal guardian **Date**

_____ _____
Signature of Witness **Date**

The Aspen Center, Inc.

Acknowledgement of receipt of Privacy Practices

_____ I acknowledge that I have received a copy of The Aspen Center, Inc.'s notice of privacy practices and how they related to protection of personal health information. I am aware that at any time I can request a current version of The Aspen Center, Inc.'s notice of privacy practices.

_____ I acknowledge that I was offered a copy of The Aspen Center, Inc.'s notice of privacy practices and how they related to protection of personal health information. However, I declined the information. I am aware that at any time I can request current version of The Aspen Center, Inc.'s notice of privacy practices.

_____

Print Client's Name

_____

Signature of parent/legal guardian

_____

Signature of Witness

_____

Date

The Aspen Center, Inc.

Acknowledgement of receipt of Fee Collection Policy

_____ I acknowledge that I have received a copy of The Aspen Center, Inc.'s fee collections policy and how it relates to protection of personal health information. I am aware that at any time I can request a current version of The Aspen Center, Inc.'s notice of fee collection policy.

_____ I acknowledge that I was offered a copy of The Aspen Center, Inc.'s fee collections policy and how it relates to protection of personal health information. However, I declined the information. I am aware that at any time I can request current version of The Aspen Center, Inc.'s notice of fee collection policy.

_____

Print Client's Name

_____

Signature of parent/legal guardian

_____

Signature of Witness

_____

Date