New Patient/Parent Forms

PATIENT:

Patient's Name:_____ Name he/she goes by:_____

DOB:_____ Gender:_____ Race: _____ Ethnicity:_____

Primary Care Physician:_____ Referred By:_____

CONTACT INFORMATION

Home Address:_____

City:_____ State:_____ Zip Code:_____

Phone:(____)_____-_____ Email: _____

Can we text you : YES NO (Circle one) NUMBER WE CAN TEXT YOU AT: _____

PARENT/GUARDIAN CONTACT INFORMATION

MOTHER

Mother's (or Foster Mother's) Name:_____ DOB: _____

Phone: _____Email: _____

Mother's Employer _____Employer Address: _____

City:_____ State:_____Zip Code: _____

.

FATHER

Father's (or Foster Father's) Name:_____ DOB: _____

Phone:_____Email:_____

Father'sEmployer:_____ Employer Address:_____

City:_____ State:_____ Zip Code:_____

Emergency Contact Person:_____Phone_____

Does the child live with both parents? Yes No If no, does the child live with Mother?____ Father?____

Who has legal custody of this child?_____

Is the child in Foster Care? Yes No If yes, when did the child come into state's custody?_____

Is this child adopted?_____ If yes, at what age?_____ Is he/she aware of this?_____

Insurance Information:

Primary Insurance Company:_____ ID#_____

Group Number:_____ Effective Dates of Plan:_____-_____

Insurance Policy Holder Name:_____DOB:_____

Secondary Insurance Company:_____ID#_____

Group Number:_____ Effective Dates of Plan:_____-_____

Insurance Policy Holder Name:_____DOB:_____

HISTORY INFORMATION

Is your child currently (or recently) under a physician's care? _____YES *NO if yes, please describe.*_____

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Is your child followed by any specialists? (Allergist, Gastroenterologist, psychiatrist, psychologist, etc.)_____

_____

Please List any medication your child takes regularly (Name and Dosage):_____

_____

Please list any known allergies: _____

_____

Does your child have unusual food preferences or other feeding issues? _____YES _____NO _____

_____

Length of mealtime: _____

DEVELOPMENTAL HISTORY

Please tell the approximate age your child achieved the following developmental milestones:

_____ Sat alone _____grasped crayon/pencil _____Babbled

_____ Said first words _____Put two words together _____Walked

_____ Walked _____ Toilet Trained _____ Dressed self

_____Stood _____Crawled _____Fed self

_____Spoke in short sentences

Your child currently communicates using (check all that Apply)

___Body Language. ___Sounds (Vowels,grunting) ____Sentences longer than 4 words

___Words (shoe, doggy, up) ___2 to 4 word sentences. ____ Other: _____

BEHAVIORAL CHARACTERISTICS (Check all that apply)

___Cooperative ___Restless

___attentive ___ Poor Eye contact

___willing to try new activities ___Destructive/aggressive

.

___Plays alone for reasonable length of time

___Separation difficulties

___Easily frustrated/impulsive

___Stubborn

___Withdrawn

___Inappropriate behavior

___Self-abusive behavior

___Easily distracted/Short attention

SCHOOL/DAYCARE HISTORY: (If your child is in school, Please answer the following):

NAME OF SCHOOL:_____TEACHER:_____

GRADE: _____

What are your child's strengths and/or best subjects?_____

_____

Is your child having difficulty in any subjects or skills?_____

_____

Is your child receiving help in any subjects?_____

Is there a current IEP in place? ____YES ____NO

THERAPEUTIC HISTORY

Has your child ever received an evaluation or therapy before? (Check all that apply):

___Speech Therapy ___Hearing ___Vision ___Occupational Therapy

___Physical Therapy ___Other: _____

How long did your child receive the above listed therapies? _____

What areas were targeted during the above listed therapies? _____

When and why were these services discontinued? _____

Does your child have any diagnosis from another healthcare provider that the therapist should be aware of? (Examples: NAS,RAD, Anxiety, Autism)_____

Who gave the above diagnosis and approximately when? _____

_____

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Is the patient in FOSTER CARE or in LEGAL CUSTODY of an INDIVIDUAL other than BIological parent ?
___YES ___NO

If you answered YES to any of the above questions please respond to the following as you are able/willing:

Patients Current Legal Name: _____ Date of Custody:_____

Nickname(s), other names that child responds to: _____

Legal Guardian's Name/Relationship: _____

Case Worker's Name: (If applicable): _____

Child has direct or indirect contact with Biological parent (s): ___YES ___NO

Frequency: _____

If there is a past history of abuse or neglect that might affect child's response to therapy, Please give a brief description: _____

_____

ASSIGNMENT OF BENEFITS

I hereby authorize and assign payment directly to Growing Wise Therapy Services LLC all insurance benefits due and otherwise payable to me for services provided by Growing WIse Therapy Services LLC. I further authorize and direct my insurance company to provide Growing Wise Therapy Services LLC with all information regarding my benefits, status of claims, reason or reasons for non-payment and any other information deemed necessary or appropriate. I hereby appoint Growing Wise Therapy Services LLC and its authorized agents and representative as my attorney- in fact for the purpose of executing all claims, Authorizations, and instructions relating to payment for services provided by GROWING WISE THERAPY SERVICES LLC.

_____ _____ _____

Parent/Guardian Signature Printed Name Date

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MEDIA CONSENT FORM AND RELEASE

I am the parent/guardian of _____ (print full name of child). I hereby grant Growing Wise Therapy Services, LLC the absolute right and permission to use pictures, digital images or videos of my child, or in which my child may be included in whole or part for any lawful purpose, including but not limited to use in any Growing Wise Therapy Services, LLC: Facebook, Instagram, Email, Newsletter, Powerpoint, or website associated with Growing Wise Therapy Services, LLC, without payment or any other consideration.

I hereby waive any right that I may have to inspect and/or approve the finished product, wherein my child's likeness appears.

I hereby release, discharge, and agree to indemnify and hold harmless Growing Wise Therapy Services, LLC with all claims, demands, and causes of action that I or my child have or may have by reason of this authorization or use of my child's pictures, digital images, or videos.

I represent that I am at least eighteen (18) years of age and am fully competent to sign this Release.

THIS IS A RELEASE OF LEGAL RIGHTS. READ IT CAREFULLY AND BE CERTAIN YOU UNDERSTAND IT BEFORE SIGNING.

PLEASE CHECK ONE OF THE BOXES BELOW THEN SIGN YOUR NAME(S)

☐ CONSENT: We/I hereby certify that We/I are/am the parent(s) or guardian(s) of the above named child and do hereby give our/my consent without reservation to the foregoing on behalf of My Child.

☐ NON-CONSENT: We/I hereby certify that We/I are/am the parent(s) or guardian(s) of the above named child and do **not** hereby give our/my consent without reservation to the foregoing on behalf of My Child.

_____ _____

(Parent(s)/Guardian's Signature) (Date)

_____

(Parent(s)/Guardian's Printed Name)

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Updated Cancellation Policy (01/02/2025)

If for any reason your child will be unable to make their scheduled appointment time, families should contact our office by phone call or text at 865-322-9252.

Non-emergency cancellations require at least 24 hours notice.

- **Examples of non-emergencies include (but are not limited to) vacations, pre-scheduled medical appointments, and family events.**

Emergency cancellations are accepted on the day of the child's appointment.

- **Examples of emergencies include (but are not limited to) child illness, illness of a family member, and a death in the family.**

Three cancellations within a 3 month period that are not reported as stated above will be equal to one no-show. After two no-shows, we will place you on a call-in list. You will be responsible to call in weekly for an appointment, as you will not have a permanent spot. After 1 month of consistent attendance, you will then be placed in a permanent spot for treatment.

In the event of inclement weather, we will provide teletherapy that day or reschedule their appointment to an in person session. If you miss a teletherapy scheduled session, this will count as a cancellation.

Retention of a minimum of 75% of your child's scheduled sessions within a 3 month period is pertinent to their progress. This means if your child is scheduled 2 times per week, missing more than 6 sessions within 3 months would result in termination of services.

If you wish to continue services after your child is discharged, you will need another referral from your child's pediatrician.

There are OPTIONS!! Teletherapy!!

We offer teletherapy as an alternative to in-clinic sessions in compliance with HIPPA guidelines.

If you are unable to attend in-clinic sessions, contact your therapist to discuss scheduling options for teletherapy. The teletherapy format provides us with the opportunity to go over your child's home program and any questions you may have related to your child's treatment.

As always, thank you for choosing Growing Wise Therapy Services. We are excited to be a part of your child's team!

Date:_____

Child's Name: _____

Parent's Signature:_____

Notice of Privacy Practices

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As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Effective: April 1st, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Memorial Health System, DBA Marietta Memorial and Selby General Hospitals and their respective physician offices, uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of Memorial Health System.

How We May Use and Disclose Medical Information About You

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, or others who need to know about you to provide quality patient care. This information may be disclosed through information we record in your medical record or verbally between health care providers. We will also provide other medical facilities with information about you and your diagnoses which they will need in order to treat you.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company or a third party. For example, we may need to give your insurance company information about a procedure we performed so we can be paid for the office visit.

For Health Care Operations: We may use and disclose medical information about you for operational purposes. For example, your health information may be disclosed to members of our staff, risk or quality improvement personnel, and others to evaluate the performance of our staff, assess the quality of care, learn how to improve our office and services.

Appointments. We may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund Raising. Memorial Health Foundation may use your information to contact you to raise funds for Memorial Health System and its health related activities. We would only release contact information such as your name, address and phone number and the dates you received treatment or services at the hospital. If you do not want the Foundation to contact you for fundraising efforts, you must notify the Memorial Health Foundation Office.

Special Situations in Which Your Information May be Released
(including in response to Federal State or Local Law)

- for judicial administrative proceedings pursuant to legal authority;
- to report information related to victims of abuse, neglect or domestic violence and to assist law enforcement officials in their law enforcement duties;
- if necessary to reduce or prevent a serious threat to your health or safety or the health or safety of another person or the public.
- in response to appropriate military authorities if you are a member of the military (including veterans)

Local Public Health Authorities

- in reporting child or elder abuse and neglect
- in reporting communicable diseases or your potential exposure to such
- in notifying you of recalls of drugs, products or devices you may be using

Deceased Patients

- to a medical examiner or coroner to assist in identifying the cause of death
- to allow funeral directors to do their jobs.

Organ/Tissue donation. Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

Workers' Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation.

We Will Always Get Your Written Authorization Before Releasing or Using Your Information:

- for marketing purposes
- in a manner that would constitute the sale of your protected health information
- in a manner not described in this notice and where required by either Federal or State Law.

Your Health Information Rights

You have a right to:

- request a restriction on certain uses and disclosures of your information as provided by *45 CFR §164.522.* This may include a limit on medical information we disclose about you to someone who is involved in your care or payment for your care, such as a family member or friend. We are, however, not required to agree to a requested restriction except in cases where you have paid your bill in full and requested a restriction on releasing your information to a group health plan, insurer, or other payor for purposes of payment or health care operations. You may request a restriction by completing a form developed by the office, or you can send a written request to the Health Information Services Department of Marietta Memorial Hospital.
- obtain a paper copy of this notice at any time from the front desk.
- inspect and obtain a paper copy of your health record and obtain an electronic copy to the extent the office utilizes an electronic medical record.
- amend your health record as provided in *45 CFR §164.526.* To request a copy or to amend your information you must make your request in writing and submit the request to the front desk or office address.
- request communications of your health information by alternative means or at alternative locations.
- revoke special authorizations to use or disclose health information for certain purposes except to the extent that action has already been taken.
- request an accounting of all disclosures of your health information when the disclosure has not been pursuant to treatment, payment, operations, or an authorization and, if your information is maintained in an electronic format, request an accounting of any disclosures dating back three years from the date of the request.
- request a hard copy of your medical information; or an electronic copy in a format requested by you if such format is readily producible.
- receive a written notification of any inappropriate release or use of your protected health information.

Obligations of Knoxville Integrative Medical Center
We are required to:

- maintain the privacy of protected health information.
- provide you with this notice of our legal duties and privacy practices with respect to your health information.
- abide by the terms of this notice.
- notify you of certain breaches or the inappropriate release or use of your information.
- notify you if we are unable to agree to a requested restriction on how your information is to be used or disclosed.
- accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations.
- release the minimum amount of your information necessary to accomplish information related functions and de-identify your information to the extent practicable.
- obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

Changes to This Notice

We reserve the right to change our information practices and to make new provisions effective for all protected health information we maintain. At the end of this notice you will be asked to sign that you have received the notice and have had the opportunity to receive a copy. Your signature is requested to help us determine which version of the notice you have received. Revised notices will be posted in the office and in registration areas throughout Memorial Health System. A paper copy will be made available to you upon request.

If you have questions or complaints, please contact:

Bonifacio Mental Health
9325 Norshore Dr
Knoxville, TN 37922

If you believe your privacy rights have been violated, you can file a complaint with the Department of Health and Human Services. There will be no retaliation for filing a complaint.

ACKNOWLEDGMENT

_____	_____	_____
Signature of Parent/Guardian	Date	Relationship to Patient

FINANCIAL POLICY

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The therapists of Growing Wise Therapy Services, LLC would like to welcome you to our practice. We strive to provide you with excellent care and our goal is to make your visit as convenient as possible.

By signing below you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office of any address or telephone number changes.
- Your financial account will need to be kept current.
- Insurance co-payments, co-insurances and deductibles are due at the time of service.
- If you have an outstanding balance at the time of your scheduled therapy session, your appointment may be rescheduled. Services may be put on hold until the balance is paid in full.
- Your insurance company may have visit limitations, it is your responsibility to be aware of these limitations and communicate those to your child's therapist.
- If your account is turned over to a collection agency, you will be responsible for any costs incurred in collections of said balance, which may include collection agency fees up to 35% of your outstanding balance, court costs and attorney fees. Services will also be discontinued.

If you have health insurance coverage:

We will submit your claims; however, we must emphasize that as clinical providers; our relationship is with you, not your insurance company. Although we attempt to verify your benefits with your insurance policy, please be advised this is only an estimate of your coverage based on the information given to us at the time of inquiry.

By Signing below you confirm that you understand:

- It is your responsibility to inform Growing Wise Therapy Services, LLC, of any changes to your insurance policy so that your coverage can be re-verified prior to your appointment. Growing Wise Therapy Services, LLC contact information is as follows: Phone 865-322-9252 Email: growingwisetherapy@gmail.com
- Not all therapy services are a covered benefit with all insurance plans.It is your responsibility to be aware of what therapy service is being provided to you and if it is a covered benefit under your insurance policy or any visit limitations.
- You are responsible for any non- covered charges not payable by your insurance policy.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, please do not hesitate to ask us. We are here to help you!

I have read and understand the above Financial Policy and agree to meet all financial obligations.

_____	_____	_____
Child's Name (Please Print)	Parent/Guardian Signature	Date

ROUTINE VERBAL SESSION PROGRESS DISCUSSIONS

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The clinical and administrative team at Growing Wise Therapy Services value our relationship with the families we serve. Much of that relationship is reinforced by regular communication about your child's progress and needs. As our time with each patient is typically limited, we strive to make the most of this time by providing therapy, followed by informative routine verbal progress reports with the parent in the lobby.

Given your signed authorization below, the therapist will share session-specific information with you verbally in the lobby at the close of each session. These discussions will be routine in nature. (Example: a report of how the session went, what they worked on, what to try at home, etc)

In the case of more sensitive issues, such as diagnosis, medical or behavioral concerns or any other personal subject, the therapist will not address these in the lobby. Depending on the available time, the therapist may invite you into the office or schedule an appointment time for a more formal conference.

At Growing Wise, we recognize that not everyone will feel comfortable with ANY discussion in a public setting, which is why we would like for you to share with us your preference regarding the session- specific routine verbal progress discussions. We will accommodate each family's discussion preferences as listed below:

REGARDING PATIENT, _____ (Check only one below)

____I authorize the staff at Growing Wise therapy to provide session-specific routine progress reports verbally in the lobby after each session, with the understanding that these discussions will be kept general in nature and will be communicated at a reasonably low volume and will not include sensitive topics such as diagnosis, medical or behavioral concerns, or any other personal subject matter.

____ I prefer that all discussions regarding my child's process, including general verbal progress reports take place either in the office or in a private conference setting. Please do not discuss anything about the session in the lobby or any public space.

_____ _____ _____

Parent/Legal Guardian's Signature Printed Name DATE

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