THERAPY IN YOUR HOME – OT, PT, ST
OUTPATIENT OCCUPATIONAL, PHYSICAL, AND SPEECH THERAPY
147 Vista Del Monte, Los Gatos, CA 95030 • Phone (408) 358-0201 • Fax (877) 334-0714
www.TherapyInYourHome.net Office@TherapyInYourHome.net

WELCOME!

Thank you for choosing Therapy In Your Home, OT, PT, ST, an OUTPATIENT therapy service provided in your home. We help match therapists with clients who need therapy in their home or community.

When working with Therapy In Your Home OT, PT, ST, the client is matched with a therapist based on the diagnosis, location, therapist specialty, and client's payer choice. To get therapy started, the following intake documentation will need to be completed in order to confirm your contact information and to whom services will be billed.

The attached documents that should be returned to us are:

1) Insurance Payment Document (2 pages)
2) Your Story! Document

- **Please note: We are not a provider of Home Health Services. We provide Outpatient Therapy which cannot be billed at the same time as Home Health Services. Thus, if you are receiving Home Health services, even periodically, you will need to pay privately for therapy provided by us if it is provided at the same time. To avoid this, please inform us if you are using any home health services.**

Tips to get the most out of your therapy services

- These are your visits. Be sure to share your goals and/or concerns with your therapist.
- The therapist will be your direct contact for scheduling and billing. Be sure to get their contact information before your first visit. Do not call the office for scheduling or cancellations.
- Missed Visits: Check with your therapist regarding their policy on cancellations. Be sure to follow their cancellation policy. Additional costs due to non- cancellation cannot be billed to insurance and will be billed to you.
- Communication helps the results of therapy.
    - Tell us or your therapist before you have an MD appointment so we can send a report
    - Involve us with your friends and family so we create a team of support. We will not share information unless OK'd by you. We follow strict confidentiality / HIPPA rules (see our website) Please help us help you by sharing names and contact information for people and agencies who might be of help to your treatment:

      _____

      _____

      _____

- You may send pictures of your insurance cards instead of completing some of the lines in the payment document.
- Please send completed and signed documents to the address, fax or email noted in our letterhead. Please write clearly and fill in information completely, otherwise it will delay start of services.

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INSURANCE PAYMENT INFORMATION Page 1 of 2

Date: _____
Patient Name:_____ **DOB**: _____
Treatment address: _____
Billing address:_____
Telephone # _____ Alt #_____
Email address: _____ **Place of work**: _____
Emergency contact person:
Name:_____ Phone: _____
Address:_____ email: _____
Name of Insured:_____ **DOB**: _____
Name of Insurance: _____ **Phone #:**_____
Name exactly as on Card: _____
ID#_____ Group#_____
Insurance Billing Address: _____
Circle all that apply: Is this plan Primary to Medicare? Y N // Are you a Veteran Y N //
Is this condition related to Employment, Auto Accident, or Other accident? Y N
Name of Secondary Insurance: _____ **Phone #** _____
Name exactly as on Card: _____
ID #: _____ Group# _____
Insurance Billing address: _____

Referring MD/Specialty: _____ **Phone:** _____
Fax #_____ **Address of MD:** _____
Other MD/Specialty: _____ **Phone:** _____
Fax #_____ **Address of MD:** _____
PLEASE ASK YOUR DOCTOR TO FAX a prescription for this therapy to 1-877-334-0714 and should include ICD-10 diagnosis codes and an updated medications list

Prior Outpatient Visits this year: PT_____ ; OT_____; ST _____
Any dates of Home Health Agency Care: _____
Complete the following information which you can get from your insurance company:
Deductible per year $_____; Copay per visit $_____;
Reasonable and Necessary rate: (See instructions below) _____; Preauthorization needed? Y__ N__
Visits allowed per year _____; Can more visits be requested Y__ N__
Procedure to request more_____
Out of pocket $_____
Please check with your therapist to confirm cancellation policy or else you will be charged privately for the visit. Visits are 1-hour long according to most insurances. **Additional time not paid by insurance will be a private charge to you.**

Continued on next page…

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INSURANCE PAYMENT Page 2 of 2

Out of Network: Monthly billing statements due on receipt. Insurance will pay you. We do not know what your insurance considers a reasonable and customary charge. It could be as low as $60. Ask them how much they reimburse for 4 units (1- hour) of CPT code 97530, or 2 units each of 97110 and 97535 in zip code 95030. For ST: 92523 ST eval and 92507 Determine if it is more cost effective for you to pay privately or for us to bill your insurance when we're not in network. Consider your copay, deductible and the difference between your charge from us and their limit.

I agree to the Rights and Responsibilities, HIPPA document on website, and to pay for services that insurance does not cover:

Patient Name: _____

Signed: _____

Print Name:
_____Relationship:_____

DATE: _____

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YOUR STORY!

Patient Name: _____
Who completed this information? _____

Please provide us with information that will help us know you better.
We appreciate this information as it helps us be better therapists for you. You can provide as much or as little information as you like. Remember: this form is used for all ages and abilities, so the questions may or may not be relevant. If you have already told us on the phone, you don't need to repeat it here.

What have you done in the past that was important to you?

How do you like to spend your time?

Who are the people and routines that help you the most through hard times?

Who are you worried about within your support network and why?

What do you know about your condition? What has your doctor told you?

How will you know if we are helping you?

What are your fears and what are your goals?

What do you see yourself doing to assist in getting those goals met?

Here's to feeling confident and satisfied!
Julie Groves and your Therapists *2/20/20*