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) Private Payment Document
2) Your Story! Document

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.
- Please complete these intake documents as much as possible; otherwise missing information may delay the start of services
- 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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PRIVATE PAYMENT INFORMATION

Date: _____
Patient Name:_____ **DOB**: _____
Treatment address: _____
Billing address:_____
Telephone # _____ Alt #_____
Email address: _____ **Place of work**: _____
Emergency contact person:
Name:_____ Phone: _____
Address:_____ email: _____
Name of Responsible Party for Payment: _____
Relationship:_____ Phone: _____email: _____

Referring MD/Specialty: _____ Phone: _____
Fax #_____ Address of MD: _____
Other MD/Specialty: _____ Phone: _____
Fax #_____ Address of MD: _____
PLEASE ASK YOUR MD TO FAX YOUR PRESCRIPTION TO 1-877-334-0714
Please attach present Medication list and keep us up to date on any changes to them.

What we need from you so we can guide you to the best reimbursement for therapy:
-Prior therapy this year; #Outpatient visits for each: PT _____ OT_____ ST_____
Who provided? _____ Why discontinued?_____
-Any Home Health Agency Care? Y N // Company:_____
-Do you have Medicare? Y N // Type of Medicare: HMO/managed_____ Straight_____ PPO_____
Is the Medicare Part A or Part B or Both A/B?_____
-If you have Medicare, you will need an ABN stating why Medicare will not be covering services.
-Do you have any secondary Insurance? Y N ID#_____ Group #_____
Name as written on the card: _____
-Other Insurance Options: Kaiser_____ Long Term Care _____ Worker's Comp_____ Medi-Cal _____
Hospice_____ Accident/Liability _____

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!

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*