INDIVIDUAL MUSIC THERAPY SESSION INTAKE FORM
(Not Submitting Insurance- Pay out of Pocket)

523 Demers Ave. Grand Forks, ND 58201
Phone: 1.218.791.0908
Fax: 1-701-775-1038
Email:Emily@musictherapyinmotion.com
Website: www.musictherapyinmotion.com

MT 1:1 Patient Information Form:

Patient's Name :_____

DOB: _____ Male / Female

Guardians or Caretaker Names_____

Billing Address: _____ City: _____ Zip: _____

Phone Number: Home _____ Cell_____

E-mail: _____

Diagnosis (if known): _____

Emergency Contact:_____

Necessary Accomidations:_____

What are your priorities in attending music therapy sessions with Music Therapy in Motion, LLC?

_____

_____

Do you currently receive other therapy services? Yes/No

If "Yes", where and when/what days:_____

How did you hear about us? _____

Are you approved for any Waivers? _____

If so, who is your waiver case manager?_____ Phone:_____

Email:_____ Fax:_____

Agency Name and Adress:_____Phone:_____

Medical History:

Does Patient have any re-occurring other medial issues? (ex. Seizures, Epilepsy,)

_____

IF SO Describe Plan of Action in case of episode: _____

_____

Any known allergies? ☐ Yes ☐ No. If yes, please describe:_____

_____

Any diet restrictions? ☐ Yes ☐ No. If yes, please describe:

_____

Anything else you would like to tell us about patient or family?

_____

_____

PERMISSION FOR CAREGIVER TO LEAVE SITE DURING TREATMENT

I _____ (Guardian) acknowledge that I am the guardian of _____ . I understand that while the patient is receiving therapy I may leave the premises. However, I will give *Music Therapy in Motion, LLC* a working cell phone number where I can be reached during my absence. In addition, I agree that I will return prior to the end of the session. I give consent and permission to *Music Therapy in Motion, LLC* for any additional treatment or transportation that may be needed in the event that the patient is injured or needs medical attention. Also, I understand that the ability to continue to leave the premises while the patient is at therapy is at the discretion of *Music Therapy in Motion, LLC* and/or the therapist.

I hereby release *Music Therapy in Motion, LLC* and any agents or assignees, from any and all claims for damages related to my leaving the premises during therapy.

PATIENT/GUARDIAN SIGNATURE _____Date: _____

PRINTED NAME _____CELL_____

SECONDARY EMERGENCY CONTACT PHONE # _____

CONSENT TO TREAT

I consent for *Music Therapy in Motion, LLC.* to provide _____with Music Therapy services. I consent to care and treatment falling under the practice of Music Therapy in Motion, LLC.

Physical Movement:

I acknowledge that there is always a risk of injury with any therapy involving physical activities. I hereby release *Music Therapy in Motion, LLC* and any agents or assignees, from any and all claims for damages related to physical movement during music therapy.

PATIENT/GUARDIAN SIGNATURE _____Date_____

PRINTED NAME: _____

ATTENDANCE POLICY:

Because of frequent no-shows and cancellations, *Music Therapy in Motion, LLC* has a policy that states that we require a 24 hour notice for cancellations. We know that sickness occurs; therefore, if you think that you are sick the night before, please call us and give us notice so we may plan accordingly, and/or contact a family who is on stand by for a make-up session or on a waiting list for an evaluation or services. In the event of a cancellation, we will make every effort to reschedule as we want you to benefit from his/her therapy. The staff at *Music Therapy in Motion, LLC* strives to meet the scheduling needs of every family. If your therapy time does not work for you, please let us know.

PATIENT/GUARDIAN SIGNATURE _____Date_____

PRINTED NAME: _____

PAYMENT: Music Therapy in Motion will bill $_____ per session and at the end of every month. The bill will come via email unless you prefer a physical bill to be mailed to your address. Your payment is due to MTIM within 30 days. You have the option to pay online when your bill is emailed. If you receive a bill via mail, you can pay by check or cash. If your payment is overdue a late charge of $25 per month will be applied to the bill. By signing below you consent to pay for service as they are rendered.

PATIENT/GUARDIAN SIGNATURE _____Date_____

PRINTED NAME: _____

CONSENT FOR AUDIO/VISUAL RELEASE

I _____ (Patient/Guardian) give permission for _____ (Name of Patient) to be audio or video taped by the therapists by or at *Music Therapy in Motion, LLC.* These audio or video taped sessions will be used for education and training purposes only (i.e., clinical supervision, conference presentations). At no time will your full name be spoken on the tapes and your full identity will remain confidential. These tapes may be maintained in a locked facility.

PATIENT/GUARDIAN SIGNATURE _____Date_____

PRINTED NAME: _____

CONSENT FOR PHOTOGRAPH RELEASE

I _____ (Patient or Guardian) give permission for _____ (Name of Patient) to be photographed by the therapists at *Music Therapy in Motion, LLC.* These photographs will be used for education and training purposes (i.e., clinical supervision, conference presentations), and may be used by *Music Therapy in Motion, LLC* for advertisement purposes (i.e., brochures, website, and newspapers).

PATIENT/GUARDIAN SIGNATURE _____Date_____

PRINTED NAME: _____