Music Therapy in Motion, LLC, 523 Demers Ave. Grand Forks, ND 58201, Phone: 1.218.791.0908,
Email:Emily@musictherapyinmotion.com Website: www.musictherapyinmotion.com

Patient Information Form:

Patient's Name :____

DOB: ________________ Male / Female

Guardians or Caretaker Names____________________________________

Billing Address: ______________________ City:____________ Zip: _______

Phone Number: Home ______________________ Cell_________________

Emergency Contact: ____

E-mail: ____

Diagnosis (if known): ____

Primary Physician: ______________________ Phone:________________

Physician's Address: ____

Other doctors and specialists who are involved in patient's care:

____

____

Languages Spoken at Home (circle primary): ________________________

Service Pets: ____

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 reoccurring other medial issues? (ex. Seizures, Epilepsy, ect…)

____

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

____

If patient has a Behavior Intervention Plan: Please attach a copy or communicate how we should handle behavioral situations: ____

Please list any recent hospitalizations, medical procedures you have received and precautions we should take: ____

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?

____

____

PATIENT/GUARDIAN SIGNATURE ____

PRINTED NAME ____

DATE ______________________**RELATIONSHIP TO PATIENT** _________________________

PERMISSION FOR EXCHANGE or RELEASE OF INFORMATION:

I authorize *Music Therapy in Motion, LLC* to release necessary and pertinent medical information to physicians, case managers, and insurance companies as needed for _______________________

Approved information may be exchanged with the following people *directly* related to the patient ____________________ care:

- ☐ Doctor's ____
- ☐ Therapist's____

Approved information includes **written documents** and/or **verbal discussion.**

PATIENT/GUARDIAN SIGNATURE ______________________**Date**__________

PRINTED NAME ____

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 # ______________________________________

An initial evaluation for music therapy services is $85. Evaluations are an out-of-pocket expense expected at the time of service. An initial evaluation will be needed at the start of therapy with our facility. Most evaluations will last 1 hour. If a family needs a re-evaluation for insurance or personal reasons, the rate will be $85. Financial arrangements will be made prior to the time of evaluation.

______ initials

CONSENT TO TREAT

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

<u>Physical Movement:</u>

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. **After a one-time occurrence, a $40 fee will be charged for EACH missed therapy appointment. This charge will be made to the patients account.** We understand 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 standby 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. If you miss 3 consecutive weeks of therapy, we will make every attempt to hold that slot, but cannot guarantee this with an extended absence.

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: ____

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).

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 can 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, Facebook, website, and newspapers).

PATIENT/GUARDIAN SIGNATURE ____**Date**______________

PRINTED NAME: ____