Music Therapy in Motion, LLC, 6046 14th St. S. Fargo, ND 58104
Music Therapy in Motion, LLC 2512 A South Washington Ave Grand Forks, ND 58201
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Please fill out this form to the best of your ability. Since this information is important in the treatment of your loved one please attach or include any additional documents relating to the individuals medical, educational (IEP/504) or psychological history.

Patient Information:

Patient's Name _____DOB_____

Age_____ Gender_____ Diagnosis:_____

Street Address_____

City/State/Zip_____Home Phone_____

Does the individual live with parent/s? Y/N _____

Parent/Guardian Information:

Guardian's Name _____ Age_____

Occupation_____

Work phone_____Cell_____

Email:_____

Address:_____

City/State/Zip_____

REASONS FOR SEEKING MUSIC THERAPY

What are your priorities in attending music therapy sessions with Music Therapy in Motion, LLC? (speech, communication, social, behavioral, cognition, rehabilitation, motor, habilitation etc…)

_____

_____

Do you currently receive other therapy services? Yes/No

If "Yes", which types/ serviceprovider/days_____

where:_____

How did you hear about us? _____

WAIVERS:

Are you approved for any Waivers (MN/ND) _____

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

Case manager Email:_____ Fax:_____

Agency Name and Address:_____Phone:_____

Does your child receive music therapy services at school? Y/N School_____

District _____ Group/1:1

Insurance Information* (Only Nessisary if you would like us to file)

Primary Insurance_____Member ID _____Group Number _____

Subscriber_____ Subscriber's Date of Birth_____

Secondary Insurance_____Member ID_____Group Number_____

Subscriber_____Subscriber's Date of Birth_____

Subscribers Social Security Number:_____ Subscribers Employer_____

Diagnosis (if known): _____ Diagnosis code 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): _____

Patient Medical History:

Does Patient have any reoccurring other medial issues? (ex. Seizures, Epilepsy etc…)

_____

IF SO Describe Plan of Action in case of episode or attach an emergency plan: _____

_____

Please list any hospitalizations and/or medical procedures you have received: _____

_____

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?

_____

_____

Services:

Please initial next to the Music Therapy service you would like to receive on a weekly basis *
* All individuals will be required be assessed or re-evaluated at the time of contract renewal. Assessment charges are $85 for 2018. _____ Please initial you understand.

2018 Music Therapy Rates

_____ 30 min Music Therapy session in clinic $35

_____ 30 min Music Therapy session in home $45

_____ 45 min Music Therapy session in clinic $55

_____ 45 min Music Therapy session in home $65

_____ 60 min Music Therapy session in clinic $75

_____ 60 min Music Therapy session in home $85

By signing below, you understand that music therapy sessions will be scheduled on a weekly basis after the initial assessment is completed. You understand that invoices will be sent out the first week of each month after music therapy services have been provided. You aknowledge you are responsible for all payments due upon receipt.

Payments can be made online through the invoice provider or through snail mail. All unpaid invoices will be charged a 1.5% late charge, up to 18% per annum.

GUARDIAN SIGNATURE _____

PRINTED NAME _____DATE _____

PERMISSION TO CHARGE CREDIT CARD:

If you would like us to help you pay in a timely manner, please provide credit card information below. Charges will be made the day the invoices are issued and an email will be sent out to the desired email address/s:_____

Credit card type:_____ Name on Credit Card:_____

Credit Card Number:_____ Expiration Date:_____ CCV_____

By signing below you are agreeing to allow Music Therapy in Motion, LLC charge your credit card account for the indicated amount on each monthly invoice which will be sent to you via email.

GUARDIAN SIGNATURE _____

PRINTED NAME _____DATE _____

PERMISSION FOR EXCHANGE 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 _____
- ☐ Therapists_____

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 # _____

Assessment/Re-evaluation:

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 or on a yearly basis to insure the client is receiving the best therapeutic treatment. Most evaluations will last 30 mins-1 hour. Your initials are requested to insure that this is completed yearly. _____ **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.

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:

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. 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. By signing below you understand that if you cancel your music therapy session without a 24 hour notice, you will be charged for your regular appointment.

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 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: _____

By signing below, I understand the terms and conditions of this contract as stated above and understand that this is a rolling agreement, meaning it is valid unless a two-week written notice is given by either party to withdraw services.

PATIENT/GUARDIAN SIGNATURE _____Date_____

PRINTED NAME: _____

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. **Authorization:** I authorize_____(healthcare provider) to use and disclose the protected health information described below to _____
(individual seeking the information)

2. **Effective Period:** This authorization for release of information covers the period of healthcare from:

❑ a._____to _____

OR

❑ b. All past, present and future periods.

3. Extent of Authorization:

❑ a. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of drug abuse).

OR

❑ b. I authorize the release of my complete health record with the exception of the following information:

❑ Mental health records

❑ Communicable diseases (including HIV and AIDS)

❑ Alcohol/drug abuse treatment

❑ Other: (please specify)_____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____
(date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____

Signature of patient or personal representative

_____

Printed name of patient or personal representative and his or her relationship to patient

_____

Date

***Only fill out this form if you would like us to submit Insurance Claims**

THIRD PARTY BILLING RELEASE

Date:_____

This letter serves as notice to clients and client guardians that our practice, Music Therapy In Motion, utilizes a third-party billing service. Only personal/health information that is pertinent to billing will be shared with the billing service. All information will remain confidential as mandated by the HIPAA privacy rules. A copy of our HIPAA policy is attached.

If billing third-party insurance plans for music therapy services, this letter serves as notice that any deductibles, co-pays and co-insurance, etc. are the responsibility of the patient or patient's legal guardian. By signing below, patient/guardian acknowledges financial responsibility for all charges associated with music therapy services. **Although every effort will be made to secure reimbursement for services through health insurance plans if desired by patient, there is no guarantee that music therapy services will be covered or reimbursed by patient's specific insurance plan. It is ultimately the patient/guardian's responsibility to pay for all services rendered in the event that medical claims are denied.**

Assignment of Benefits/Release of Medical Information

With my signature below I hereby authorize all of my insurance companies to make payment directly to Music Therapy In Motion. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance company. I authorize the release of any medical information necessary to process these claims.

_____
Patient or guardian signature

_____
Date

Please fill this form out only if you would like us to file claims to your INSURANCE

Client intake/insurance form for Third Party Insurance Biller

Client name_____ Date_____

Client date of birth_____ Client gender_____

Legal guardian's name (if applicable)_____

Relationship to client_____

Home phone_____ Cell phone_____

Street address_____

City_____ State_____ Zip_____

Email_____

Client diagnosis_____

Would you like us to contact your insurance company to check on potential music therapy benefits? Yes or No

If yes, please provide the following information:

Insurance company name_____

Member ID#_____

Group ID#_____

Name of insured_____

Name of employer_____

Birth date of insured_____

Relationship of insured to client_____

Social security number of insured_____

Phone number for benefits verification (listed on back of insurance card)

_____

Are there any other therapists billing this insurance policy?

___Physical therapy ___Occupational therapy ____Speech therapy

___Behavioral/mental health ___ABA Therapy ___Other:_____

Has this client been approved for funding through a state Medicaid waiver program? Yes or No

If yes, please provide details:
_____

Please complete this section about the client's Primary Care Physician:

Physician Name_____

Address_____

Phone_____ Fax_____

By signing below, client/guardian authorizes this practice to contact the primary care physician and health insurance company listed on this form for the purposes of reimbursement. Client/guardian acknowledge financial responsibility for music therapy services rendered if third party reimbursement is unable to be obtained.

_____ _____
Client signature Guardian signature

***Please attach a photocopy of front and back of client's insurance card to this form.**