Dogwood
Therapy Services Inc.

Welcome to Dogwood Therapy!

You are receiving this packet because you or your physician has inquired with us for occupational therapy services. Attached you will find our new client packet. Our openings are limited, and dependent upon your completion of the requested information. Please return it within 10 days. Please contact us at info@dogwoodtherapy.com or 505-228-4650 should you need assistance.

A complete packet consists of:

- ☐ Primary care physician's referral for occupational therapy evaluation and treatment, along with all ICD-10 diagnosis code(s).
- ☐ A copy of the front and back of ALL insurance cards for the new patient. (including Medicare, Medicaid, Centennial Care, Regular/Private Healthcare Insurance, Mi Via Contract, etc.)
- ☐ This packet, filled out completely.
- ☐ Copies of any relevant healthcare evaluations or reports within the past year.

Once we receive all of the above, we will submit for insurance authorization for the initial evaluation. This takes 1-2 weeks, and then we will call to schedule an appointment.
If you do not hear from us within 14 business days, please email or call us to check on the status. info@dogwoodtherapy.com 505-228-4650. We look forward to meeting you!

Melissa Winkle, OTR/L; FAOTA
Dogwood Therapy Services

INFORMATION AND EMERGENCY FORM Todays Date: _____

Client Name: _____ Date of Birth: _____
Home Address: _____
Home Phone _____ Cell Phone _____
SS# _____ email: _____

Parent #1: _____ Parent #2: _____
Employer: _____ Employer: _____
Phone: _____ Phone: _____
Email: _____ Email: _____

Caregiver (if other than parent) _____ Phone: _____
Address: _____
Email: _____

All diagnoses, illnesses/medical conditions (environmental/food/medication allergies, asthma, seizures, etc):

_____

_____

Current medications: _____

_____

_____

Relevant medical history (prenatal care, birth, developmental milestones, surgeries/illness/injuries, therapies):

_____

_____

_____

Please list any additional concerns: _____

_____

_____

Who is allowed to drop off and pick up the participant? _____

_____

In case of illness or accident, and you cannot reach me, you are authorized to notify:
Name: _____ Phone (____) _____
Relationship: _____
Name: _____ Phone (____) _____
Relationship: _____
If unable to reach anyone, please contact my physician and follow his orders:
Physician: _____ Phone (____) _____
Hospital Preference: _____
It is understood that the parent/caregiver is responsible for further emergency transportation and care:
Signed: _____ Date _____

Dogwood Therapy Services Inc
3108 Alamogordo DR NW, Albuquerque, NM 87120-1108
customerservice@dogwoodtherapy.com 505-228-4650 fax 866-904-9976
www.dogwoodtherapy.com

Funding Information and Verification for Services **Date:** _____

Clients Name: _____ DOB: _____ Male/Female SS#_____

Client Address: _____

City/State _____ Zip: _____ Client Phone _____

Parent/Guardian Name(s): _____

Home Phone: _____Cell Phone:_____ email: _____

Guardian Address: _____ City/State/Zip _____

Client PCP: _____ PCP NPI#: _____

Phone: _____ Fax: _____

☐ **Copy of prescription for service (occupational therapy) with a diagnosis code.**

Client Diagnoses: _____

Funding Source:

☐ Does client have **MedCARE?** ☐Yes ☐ No MediCARE Claim Number_____

Entitled to Part B (Medical)? ☐Yes ☐ No Effective dates _____ ☐ **Copy both sides of insurance card**

☐ Does Client have **MediCAID?** ☐ Yes ☐ No MediCAID Member Number _____

Effective Date: _____ Renewal Date: _____ ☐ **Copy both sides of insurance card**

☐ Does parent/guardian/client have **workplace/private insurance plan** (Primary Insurance)? List below.

Primary Insurance Company: _____

Policy Holder Name: _____ DOB: _____ Policy holder SS#_____

Employer of the Insurer: _____

Policy Group #: _____ Policy ID# _____ □ **Copy both sides of insurance card**

☐ Does Client have alternative funding such as:

☐Mi Via! ☐ Developmental Disability Waiver ☐ Medically Fragile ☐ Other: _____

Case Manager Name and Phone number: _____

☐ Private Payment ☐ Other _____

For Office Use Only **Insurance Verification**

ICD 10 DX Codes: _____ **Are these Dx covered for OT:** _____

Coverage ☐ OT **Combined disciplines?** Yes / No **Therapy Setting**: Clinic Home Community

Coverage year start date:_____ Co-pay each visit $ _____ Deductible/year: _____

How much deductible has been used to date? _____ Co-Insurance %/amount:_____

Eval Required ? Yes / No **Written Report Required**? Yes / No **Frequency:** _____

Auth # if required: _____ **Auth Dates** _____ Eval? _____# **visits** _____

Frequency and duration of OT Services _____ hrs per visit _____ per month for _____months

Is a unit a ☐ visit or ☐15 minutes? Max units per visit? _____ Select allowable for the participants' diagnosis:

OT Service Code	Modifier	Allowable # units/ session	OT Service Code	Modifier	Allowable # units/session
97003			97530		
97004			97532		
97110			97533		
97112			97535		
97140			G0152		HOME VISIT
97530					

Dogwood Therapy Services Inc
3108 Alamogordo DR NW, Albuquerque, NM 87120-1108
customerservice@dogwoodtherapy.com 505-228-4650 fax 866-904-9976
www.dogwoodtherapy.com

AUTHORIZATION TO RELEASE INFORMATION

I/we authorize the release of any medical information necessary to process payment claims. I also give consent to the school, physician, clinic or agency specified below to release/obtain information concerning the diagnostic record and/or verbal exchange or information for the client receiving treatment. Please list team members (teachers, physicians, other therapists, etc) along with contact information.

Name and address: _____

Email and phone number: _____

Name and address: _____

Email and phone number: _____

Name and address: _____

Email and phone number: _____

_____

Client/Guardian Signature Date

AUTHORIZATION TO TREAT A MINOR

I authorize intervention for the minor named _____by a qualified, licensed therapist. This child is covered on the undersigned legal guardian's insurance policy. In case of divorce, legal documentation will be required to verify financial responsibility.

_____

Client/Guardian Signature Date

DIAGNOSTIC TESTING/REPORTS

I understand that insurance companies may not cover diagnostic testing and formal reports and other specific procedures. Evaluations charges vary depending upon content and time, reports will be charged at the rate of $50 per hour. I will be notified of these charges prior to services and agree to pay if the insurance company denies these services.

_____

Client/Guardian Signature Date

TRANSPORT RELEASE

I give my permission to the staff, interns, and volunteers to transport _____ to and from activities. I expect that every reasonable care will be exercised to insure their safety. I recognize in the event of an unexpected, unavoidable accident that Dogwood, staff, interns, and volunteers will not be held liable.

_____

Client/Guardian Signature Date

ABSENCES/LATE ARRIVALS

I/We, acknowledge we have read and understand the Absentee Policy. **There will be a $30 cancelation fee charged for appointments that are not attended, unless the office is notified 24 hours in advance.** Contact information is listed below. This will allow therapist time to reschedule missed appointment or evaluations for others. You may contact our office and leave a message for your therapist. Clients who miss more than 3 appointments in a 3-month period will be removed from the regular time schedule. Therapists are required to wait only 15 minutes after a session begins, in the event of late arrivals. It is the caregiver/client responsibility to call for rescheduling.

_____

Client/Guardian Signature Date

CO-PAYMENTS/CANCELATION/ABSENCE FEES

I agree to pay a $30 cancelation fee charged for appointments that are not attended, unless the office is notified 24 hours in advance. Contact information is listed below. I agree to pay the insurance copayments and or deductible according to my insurance policy. I agree/understand this amount is due on the date of service, prior to the treatment session. (Only applicable for private insurance and private contracts.) Outstanding balances will result in removal from therapists' schedule.

_____

Client/Guardian Signature Date

Dogwood Therapy Services Inc
3108 Alamogordo DR NW, Albuquerque, NM 87120-1108
customerservice@dogwoodtherapy.com 505-228-4650 fax 866-904-9976
www.dogwoodtherapy.com

PAYMENT RESPONSIBILITY

I understand that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I agree that if the private insurance company denies any and all claims or that therapist are not notified when my insurance has changed/terminated prior to services, I will pay for the total allowable amount due for all treatment sessions. If there are unpaid insurance claims that need resolutions the billing department will notify me in a timely manner. I may also choose to contract with therapist on a private pay basis if prior authorizations are denied. I acknowledged that I may contact my own insurance company and file a grievance of non payment. If I am not satisfied with the decision, I may file an appeal. If I am not still satisfied with the result of the appeal, I can file a grievance with the New Mexico State Regulation and Licensing Department according to their procedures. (Medicaid and Medicare are exempt from payment.)

_____

Client/Guardian Signature Date

STATEMENTS

In some cases, I may qualify to receive a monthly statement with my deductible or co-pay/coinsurance balance. This balance is due upon receipt. I understand that if my balance is over 30 days late, if no agreement is made between me and treating therapist that services will stop until payment is made in full. (Only applicable for private insurance and private contracts.)

_____

Client/ Guardian Signature Date

FINANCE CHARGES

I understand that a 10% finance charge can be applied for charges past due of 30 days if no attempt has been made for resolution of payment. (Only applicable for private insurance and private contracts.)

_____

Client/Guardian Signature Date

COMPLAINT/GREIVENCE PROCEDURES

If I have any complaint about any of the services provided, the quality of care I receive, I will call the Facility Director, Melissa Winkle, OTR/L, FAOTA at 505-228-4650. I will notify them in person, by letter, or by telephone, when I have a complaint. The complaint will be reviewed within 30 calendar days. If I am not satisfied with the outcomes, I may file an appeal. If I am still not satisfied with the result of the appeal, I have the opportunity to hire a neutral mediator, or finally, file a grievance with the New Mexico State Regulation and Licensing Department according to their procedures.

_____

Client/Guardian Signature Date

RECEIPT of PRIVACY PRACTICES

I have received a notice of privacy practices for my records. I understand that information regarding clients is privileged and not shared or distributed to anyone without my signed authorization.

_____

Client/Guardian Signature Date

AUTHORIZATION FOR STUDENT/VOLUNTEER PARTICIPATION

Dogwood Therapy Services supports the development of local, national and international interns in healthcare occupations and dog training, via fieldwork experiences through out the year. Volunteers and interns are trained in privacy practices, and may have access to your healthcare information. We are sometimes able to offer additional sessions without fees with trained community volunteers, under the supervision of a licensed provider (occupational therapist, etc.). I give permission to allow interns and volunteers to observe/interact and have access to verbal or written information involving the participant.

_____

Client/Guardian Signature Date

Dogwood Therapy Services Inc
3108 Alamogordo DR NW, Albuquerque, NM 87120-1108
customerservice@dogwoodtherapy.com 505-228-4650 fax 866-904-9976
www.dogwoodtherapy.com

Dogwood Therapy Services Client Intake Questionnaire

Client Name:	DOB:	Parent/Guardian Name & Contact #:

1. Why is participant seeking Occupational Therapy services? _____
2. Are there already established goals? _____
3. Has participant seen an OT before? When? _____
4. Was participant referred specifically for animal-assisted therapy or assistance dog related intervention? Briefly explain: _____
5. Has participant ever witnessed or participated in mistreatment of insects or animals? Briefly explain: _____
   _____
6. Does participant have allergies to latex, foods, animals?_____
7. Does participant have any mental health diagnoses? If so, please list: _____
8. Does participant have any sensory processing concerns? Briefly explain: _____
   _____
9. Does participant have any behavioral or psychiatric concerns? Briefly explain: _____
   _____
10. How and where does participant spend time during a typical day? _____
    _____
11. Does participant have friends/peers that he/she sees or talks to regularly? _____
12. If we asked the person above if they were friends with the patient, would that person agree that they were friends?
    _____
13. Is participant comfortable in a group setting? Briefly explain:_____
14. How does participant express thoughts, feelings, opinions? _____
15. What are participant's current life stressors and how does participant cope?_____
    _____
16. What interests, hobbies and activities does participant enjoy? _____
17. What angers the participant? And what are the outcomes? _____

Dogwood Therapy Services Inc
3108 Alamogordo DR NW, Albuquerque, NM 87120-1108
customerservice@dogwoodtherapy.com 505-228-4650 fax 866-904-9976
www.dogwoodtherapy.com

Circle ONE			Guardian/ Client Initial
Yes	**No**	I understand the concept of Animal Assisted Therapy and give my permission for the above named person to participate in such activities. I understand that the animals used in session activities are in training or have historically participated in basic obedience and/or advanced professional training, and that the animals have been evaluated by professionals in the animal training or animal care and human services fields. I understand that animals may still have primitive reactions to environmental stimuli and the actions of people.	
Yes	**No**	I understand that pre and post program or treatment data will be collected to measure and compare overall skill development. I understand that this data may be used to improve program activities, to demonstrate the usefulness of this type of program, and may be published as described below.	
Yes	**No**	I give permission to Dogwood Therapy Services, Melissa Winkle, all participating associates (paid, contract, or volunteer), and those acting under their permission, to talk or write about, publish, photograph, case study, interview, video, record, research, copyright, use and publish information and images that show or describe me participating in therapeutic activities with or without dogs.	
Yes	**No**	I give permission for newspapers, magazines, books or TV stations to make and publish photographs or videos that show or describe me participating in therapeutic activities with or without dogs.	
Yes	**No**	I understand that this is an emerging and evolving area of therapeutic intervention and that the images, recordings and publications will be used to educate professionals about the therapeutic use of animals, the use of animals as assistive technology options, and the related therapeutic outcomes.	
Yes	**No**	I understand that the images, recordings and publications may be used for but are not limited to local, national and international continuing education lectures, publications, advertisement, packaging, promotion and sales materials, and solicitation of contributions/grants.	
Yes	**No**	I hereby indemnify and hold Dogwood Therapy Services, Melissa Winkle, and all participating associates (volunteer or paid) harmless from and against all claims, losses, liabilities, and damages to persons or property, governmental charges or fines and attorney's fees or mediators arising out of the acts or omissions of any activities or sessions. These include but are not limited to interactions with therapists, volunteers, instructors, attendees, and animals. I understand that all precautions have been taken to ensure safety.	
Yes	**No**	I give my permission for volunteers, contractors and interns to have access to my written or verbal healthcare information so they may better assist and participate in the intervention process.	
Yes	**No**	I understand that I have the right to **NOT** give this permission or change my mind at any time. If I change my mind, I understand that I must submit a retraction of permission in writing prior to any ***future*** publications.	
Yes	**No**	I attest that the information that I have given regarding history, treatment and funding, in all sections of this packet, is complete and accurate. I am authorized to give this information.	

_____ _____ _____

(PRINT Program Participants Name) (Signature of Program Participant) (Date)

_____ _____ _____

(PRINT Guardian Name) (Guardian Signature) (Date)

Dogwood Therapy Services Inc
3108 Alamogordo DR NW, Albuquerque, NM 87120-1108
customerservice@dogwoodtherapy.com 505-228-4650 fax 866-904-9976
www.dogwoodtherapy.com