Trident Lake Health Inc.
Trident Lake Abilities Care (TLAC) — Pediatric PT · OT · Speech Therapy
4140 E Bethena St, Gilbert, AZ 85295
Phone (480) 256-9633 | Fax (480) 631-0526 | info@tridentlakehealth.com | www.tridentlakehealth.com

CLIENT INTAKE PACKET — PEDIATRIC THERAPY (DDD)

Pediatric Physical, Occupational & Speech-Language Therapy

TO AVOID DELAYS IN TREATMENT: return this completed packet with a copy of the parent/guardian's photo ID and the front and back of all insurance cards within 48 hours.

CLIENT INFORMATION

Client Name First _____ Middle _____ Last _____

Date of Birth _____ Sex ◯ Male ◯ Female ◯ Other AHCCCS / DDD ID # _____

Address _____

City _____ State _____ ZIP _____

Primary Phone _____ Alternate Phone _____

Parent/Guardian 1

Name _____ Relationship _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Email _____

May we leave a message? ◯ Yes ◯ No May we email you? ◯ Yes ◯ No

Parent/Guardian 2

Name _____ Relationship _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Email _____

May we leave a message? ◯ Yes ◯ No May we email you? ◯ Yes ◯ No

Emergency Contact (other than parent/guardian)

Name _____ Relationship _____ Phone _____

SERVICES & CARE PREFERENCES

Services requested ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech-Language Pathology

Preferred setting ☐ In-home (natural environment) ☐ Telehealth ☐ Community (daycare/school) ☐ No preference

Service address, if different from home _____

Preferred days ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat **Times** ☐ Morning ☐ Afternoon ☐ Evening

Preferred Language _____ Interpreter needed? ◯ Yes ◯ No

DAY / TREATMENT FACILITY

Does the client attend a day or treatment facility? ☐ Group home ☐ DTT ☐ N/A

Facility Name _____

Days/Hours of Attendance _____ Transportation Method _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Facility Contact _____

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PHYSICIAN, SUPPORT COORDINATOR & INSURANCE

Primary Care Physician

Address | Phone | Fax

DDD Support Coordinator

SC Phone | SC Email

Primary Insurance

Insurance Company

Member/Policy # | Group #

Policy Holder | Holder DOB

Relationship to Patient | Holder SSN (last 4) | Employer

Secondary Insurance

Insurance Company

Member/Policy # | Group #

Policy Holder | Holder DOB

Relationship to Patient | Holder SSN (last 4) | Employer

SOCIAL & ACADEMIC

Who lives in the home?

Language(s) the child speaks | Primary language

Attends school or preschool? ◯ Yes ◯ No If yes, grade

Performs at grade level in: Reading ◯ Yes ◯ No Math ◯ Yes ◯ No

Has an Individualized Education Plan (IEP)? ◯ Yes ◯ No Receives special education services? ◯ Yes ◯ No

Concerns with social skills? ◯ Yes ◯ No If yes, describe

What does the child like to do in free time?

Favorite toy or item (e.g., cars, doll)

The child currently communicates using (check all that apply)

- ☐ Body language / facial expressions
- ☐ Sounds (vowels, grunting)
- ☐ Words (ball, go, more)
- ☐ 2–4 word phrases (“more ball”)
- ☐ Sentences of 5+ words
- ☐ Other (sign, AAC, PECS):

Does / did the child… (check all that apply)

- ☐ String sounds or word approximations (“bup” for cup)
- ☐ Imitate sounds/words after a model
- ☐ Have difficulty learning letters, numbers, colors
- ☐ Understand the concept of yes/no
- ☐ Have difficulty producing specific sounds
- ☐ Have difficulty understanding what he/she reads
- ☐ Repeat scripted phrases (from shows, out of context)
- ☐ Retrieve or point to common objects
- ☐ Follow simple directions (“go sit down”)
- ☐ Respond appropriately to ‘wh’ questions
- ☐ Show dysfluent speech (stuttering)
- ☐ Have difficulty with writing

MOBILITY

Balance while standing ◯ Excellent / no concern ◯ Moderate (stumbles) ◯ Poor (very unsteady, falls)

Uses adaptive aids for balance? ◯ Yes ◯ No

Independent mobility ☐ Crawling/Scooting ☐ Kneeling ☐ Standing ☐ Walking ☐ Running ☐ Climbing

Mobility aids ☐ N/A ☐ Walker ☐ Cane ☐ AFOs ☐ Leg braces ☐ Wheelchair ☐ Other:

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FEEDING / DIET

Independent with utensils	◯ Yes	◯ No	
Independent with specific utensils	◯ Yes	◯ No	
Requires limited assistance (eating)	◯ Yes	◯ No	
Requires significant assistance (eating)	◯ Yes	◯ No	
Food presents a choking hazard	◯ Yes	◯ No	
Tube feeding	◯ Yes	◯ No	
Independent with any cup/glass	◯ Yes	◯ No	
Independent with adaptive equipment	◯ Yes	◯ No	
Requires limited assistance (drinking)	◯ Yes	◯ No	
Requires significant assistance (drinking)	◯ Yes	◯ No	
Independent obtaining/requesting food/drink	◯ Yes	◯ No	

Required food consistency ◯ Normal ◯ Chopped ◯ Pureed

Special liquid intake needs _____ System for fluid intake _____

PERSONAL CARE SKILLS

Level of help	Dressing	Toileting	Bathing	Dental care	Menses	Other
Independent	◯	◯	◯	◯	◯	◯
Requires prompting/reminding	◯	◯	◯	◯	◯	◯
Requires limited assistance	◯	◯	◯	◯	◯	◯
Requires significant assistance	◯	◯	◯	◯	◯	◯

BEHAVIORAL CONCERNS (IF APPLICABLE)

Behavior	Brief description	Approximate frequency	Recommended intervention
Aggression			
Self-injurious behavior			
Property destruction			
AWOL / elopement			
Self-stimulation			
Sexual acting out			
Other			

Please explain any other concerns you may have:

What are your goals for therapy?

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BIRTH & DEVELOPMENTAL HISTORY

Full term? ◯ Yes ◯ No Premature? ◯ Yes ◯ No If yes, weeks _____

Delivery ◯ Vaginal ◯ Cesarean Birth weight _____ lbs _____ oz Length _____ in

Complications during pregnancy? ◯ Yes ◯ No Describe _____

Complications during labor/delivery? ◯ Yes ◯ No Describe _____

Age child first: Sat alone _____ Crawled _____ Walked _____ Toilet trained _____

Babbled _____ Single words _____ Two words together _____

Hearing checked? ◯ Yes ◯ No Date _____ Passed? ◯ Yes ◯ No

Vision checked? ◯ Yes ◯ No Date _____ Passed? ◯ Yes ◯ No

MEDICAL HISTORY

Current medications and doses:

Allergies

Food ◯ Yes ◯ No _____

Medication ◯ Yes ◯ No _____

Bee stings ◯ Yes ◯ No _____

Latex ◯ Yes ◯ No _____

Other ◯ Yes ◯ No _____

Has the child had any of the following? If yes, give approximate date / frequency / reason.

Adenoidectomy	◯ Yes ◯ No		Allergies	◯ Yes ◯ No	
Asthma	◯ Yes ◯ No		Autism	◯ Yes ◯ No	
Down syndrome	◯ Yes ◯ No		Ear infections	◯ Yes ◯ No	
Feeding problems	◯ Yes ◯ No		Head injury	◯ Yes ◯ No	
Hearing deficit	◯ Yes ◯ No		Seizures	◯ Yes ◯ No	
Ear tube replacement	◯ Yes ◯ No		Frequent virus/colds	◯ Yes ◯ No	
Vision difficulties	◯ Yes ◯ No		Other	◯ Yes ◯ No	

Major surgeries ◯ Yes ◯ No _____

Major accidents ◯ Yes ◯ No _____

Seen any other specialist (audiologist, psychologist, neurologist, etc.)? ◯ Yes ◯ No

If yes, type of specialist, date seen, and conclusions/suggestions:

Previously treated for speech, feeding, occupational, music, or physical therapy? ◯ Yes ◯ No

If yes, dates/type of therapy, reason, clinic name, and therapist's conclusions/suggestions:

Assistive & Protective Devices

Vision _____ Hearing _____ Dental appliances _____

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Protective devices — purpose

Instructions for use

Other individual health care routines

Family history of learning disabilities or developmental difficulties? ◯ Yes ◯ No

If yes, please explain:

Hereditary speech/language, hearing problems, or physical disabilities in the family? ◯ Yes ◯ No

If yes, please explain:

What do you think may have caused the problem for which the child needs therapy?

Has the problem changed since it was first noticed? ◯ Yes ◯ No

If yes, how?

Any additional information that might be helpful for treatment:

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CONSENTS & AUTHORIZATIONS

RELEASE OF MEDICAL INFORMATION

I authorize Trident Lake Abilities Care (TLAC) to release and exchange relevant information, including diagnoses and records of treatments or examinations, with the client's insurance company or companies, AHCCCS/DDD and the client's DDD Support Coordinator team, other third-party payers, and the client's physicians and other health care providers. I also authorize those parties to release the client's records to Trident Lake Abilities Care (TLAC). A copy of this authorization is as valid as the original.

Parent/Guardian Signature _____ **Date** _____

ASSIGNMENT OF BENEFITS

I request that payment of authorized insurance and DDD/AHCCCS benefits be made on the client's behalf directly to Trident Lake Health Inc. dba Trident Lake Abilities Care (TLAC).

Parent/Guardian Signature _____ **Date** _____

CONSENT FOR CARE

I give consent for Trident Lake Abilities Care (TLAC) to evaluate and provide the therapy treatment considered necessary and appropriate for the above client's condition. I may withdraw consent at any time.

Parent/Guardian Signature _____ **Date** _____

AUGMENTATIVE & ALTERNATIVE COMMUNICATION (AAC) DEVICES

If the client is recommended for or requires an AAC device, I agree it is my responsibility to make sure the device is present and charged for all scheduled sessions. I understand the client's Support Coordinator will be notified of continued or repeated failure to follow this policy.

Parent/Guardian Signature _____ **Date** _____

TELEHEALTH INFORMED CONSENT (COMPLETE IF TELEHEALTH IS SELECTED)

Telehealth sessions with Trident Lake Abilities Care (TLAC) use a secure, HIPAA-compliant video platform. I understand that: telehealth has the same confidentiality protections as in-person care; technical problems may interrupt a session, and the therapist may reschedule or switch to phone; the therapist may decide a visit must be in person; I can withdraw consent and request in-person services at any time; a responsible adult must be present for patients under 18; and in an emergency during a session, the therapist will call 911 to the location I provide.

Patient location during telehealth (address) _____

Has a device with camera and reliable internet? ◯ Yes ◯ No

Patient/Guardian Signature _____ **Date** _____

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ATTENDANCE POLICY

Consistent attendance is essential to progress. We understand that life happens and will work with your family on rescheduling, alternate days/times, or our flex schedule. Please review and sign below. Questions: (480) 256-9633.

Topic	Policy
Late arrival	A 15-minute grace period applies. Arrival (or, for in-home visits, availability) after 15 minutes counts as a no-show; please call to schedule a make-up. Every two late arrivals place the client's active status under review.
Cancellations	Call at least 24 hours ahead. Cancellations are offered as telehealth when appropriate and are rescheduled at the time of cancellation. Make-up sessions may be with a different provider. Three cancellations of any kind within six weeks place the client's active status under review.
No-shows	No contact before a missed appointment is a no-show. One no-show is allowed per calendar year; a second may result in discharge.
Chronic attendance concerns	TLAC may remove the client from the current schedule, place the client on a flex schedule, or discharge for two or more no-shows and/or three or more cancellations in six consecutive weeks.
During the session	In-home and telehealth: a parent/guardian or responsible adult (18+) must remain present in the home for the entire session. Community setting: the facility's staff must be available on site.

The management team has final discretion on enforcement and extenuating circumstances. This policy may change; I will be notified of changes.

By signing, I acknowledge that I have read, understand, and agree to follow the TLAC Attendance Policy.

Client's Name (printed) _____ Date _____

Parent/Guardian Signature _____ Relationship _____

FLEX SCHEDULE POLICY

Instead of a fixed weekly appointment, a flex-schedule client is offered available appointments in their discipline and area. This option helps families who cannot keep the same weekly time or who would otherwise be discharged for attendance.

Cancellations & late arrivals	Flex clients follow the same cancellation and late-arrival rules as scheduled clients.
Declined offers	After five consecutive declined appointment offers, the client is recommended for discharge.
No-return-call list	After three unanswered contact attempts, the client is placed on the No-Return-Call list and is not contacted until the family calls to resume. Up to four weeks on the list is allowed, once per calendar year; then services are discontinued.
No-shows	No-shows are not allowed on the flex schedule and result in a discharge recommendation.
Flex due to attendance	To return to a fixed schedule: complete 8 weeks of flex appointments with no cancellations or late arrivals; the family then contacts us to set a new fixed schedule.

By signing, I acknowledge that I have read, understand, and agree to follow the TLAC Flex Schedule Policy.

Client's Name (printed) _____ Date _____

Parent/Guardian Signature _____ Relationship _____

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name _____ DOB _____

I voluntarily authorize Trident Lake Abilities Care (TLAC) to disclose or exchange the patient's health information, in writing or verbally, with the person(s) or organization(s) listed below, in addition to the parties named in the Release of Information in this packet.

#	Name / Organization	Relationship	Phone	Fax or Email
1				
2				
3				

Information to release: ☐ All records ☐ Evaluations / plans of care ☐ Progress notes ☐ Billing ☐ Other: _____

This authorization expires on _____ (if blank, one year from the date signed)

Redisclosure: once information is disclosed to the recipient above, it may no longer be protected by federal privacy law and could be redisclosed. Right to refuse or revoke: I may refuse to sign or revoke this authorization at any time by written notice; this will not affect the patient's treatment, payment, or eligibility for services. Revocation takes effect when received, except for actions already taken in reliance on this authorization.

Printed Name _____ Relationship to Patient _____

Parent/Guardian Signature _____ **Date** _____

NOTICE OF PRIVACY PRACTICES — ACKNOWLEDGEMENT

Trident Lake Abilities Care (TLAC) protects the patient's health information as required by HIPAA. A full Notice of Privacy Practices is available on request at any time and at www.tridentlakehealth.com. In summary, we may use and disclose health information:

- Treatment — to coordinate care with your physicians and other providers.
- Payment — to bill and collect payment from you, your insurance, or other payers.
- Health care operations — quality review, training, licensing, and accreditation activities.
- As required by law — including reports of suspected abuse, neglect, or exploitation and to avert a serious threat to health or safety.
- Appointment reminders — by phone, voicemail, text, or email, based on the preferences you gave above.
- We will not use your information for marketing without your written authorization.
- Care coordination — with the client's DDD Support Coordinator and team, and with providers working with the client under business associate agreements.

You have the right to request a copy of your records, request corrections, request limits on certain disclosures, request confidential communications, and receive an accounting of disclosures. Questions or privacy complaints: (480) 256-9633 or info@tridentlakehealth.com.

By signing below, I acknowledge that I received or was offered the Notice of Privacy Practices.

Patient/Guardian Signature _____ **Date** _____

PRE-SERVICE ORIENTATION ACKNOWLEDGEMENT

By signing below, I confirm that the information in this packet is complete and accurate to the best of my knowledge, that it serves as my pre-service orientation, and that it will be reviewed by Trident Lake Abilities Care (TLAC) provider(s) before services begin. I will tell Trident Lake Abilities Care (TLAC) about any changes.

Patient/Guardian Signature _____ **Date** _____

OFFICE USE ONLY

Received by _____ Date _____ Chart / MR # _____

☐ Photo ID copied ☐ Insurance cards (front/back) copied ☐ Eligibility verified ☐ Entered in EMR

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