



Dear Parent/Caregiver,

Welcome to Achievement Therapy Services! We are excited to be able to assist you and your child in his or her development. We pride ourselves on quality service provision and are committed to doing what we can to serve your family best.

The enclosed packet is important information which is needed before we can proceed with your child's therapy. Please complete these forms and return them to our office as soon as possible, as we cannot begin services for your child until they are received. If you have any questions, please feel free to contact our office at the number listed below.

Again, we look forward to providing the best services possible for your child and family. Let us know how we can help!

Sincerely,  
Achievement Therapy Services

Child's Name: \_\_\_\_\_

Today's Date  
\_\_\_\_\_

# NEW PATIENT REGISTRATION

## Personal Info

*Please fill in completely and legibly*

Circle one

Child's Name: \_\_\_\_\_

M      F

DOB \_\_\_\_\_ AGE \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Relationship \_\_\_\_\_

Address (list for both parents if not the same) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Mother's Phone#: (h) \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_

e-mail: \_\_\_\_\_

Father's Phone #: (h) \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_

e-mail: \_\_\_\_\_

Notes/concerns/allergies, etc. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Referral Info

*All info is required*

How did you hear about ATS Clinic (if referred by a friend, please provide their name and address so we can send them a thank you gift. \_\_\_\_\_  
\_\_\_\_\_

Primary/Referring Physician: \_\_\_\_\_

Practice/Office Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Information as written on prescription, include date: \_\_\_\_\_  
\_\_\_\_\_

Child's Name: \_\_\_\_\_ D.O.B \_\_\_\_\_ age \_\_\_\_\_

# CLIENT INFORMATION

## Concerns

Parent's concerns (try to be specific or provide examples)

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Medical Diagnosis (if applicable) \_\_\_\_\_

## History

Pregnancy & Birth History:

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Medical History (including surgeries, hospitalizations, significant illnesses or invasive procedure such as BOTOX)

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Developmental History:

rolling (back to stomach) \_\_\_\_\_ months  
sitting (hands free to play) \_\_\_\_\_ months  
crawling (hands and knees) \_\_\_\_\_ months  
walking \_\_\_\_\_ months  
primary language in the home \_\_\_\_\_

babbles    yes    no  
1st word \_\_\_\_\_ @ \_\_\_\_\_ months  
communicates verbally    yes    no  
speaking in phrases    yes    no  
sensory aversions \_\_\_\_\_

## Services

PLEASE PROVIDE NAMES, ADDRESSES & PHONE NUMBERS TO ALL SPECIALISTS WHO TREAT YOUR CHILD.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Other services previously or currently received (include school therapies)

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Daily routine (include sleeping schedule and school schedule) \_\_\_\_\_

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Child's Name: \_\_\_\_\_

# IMPORTANT COMPANY POLICIES

*Please initial each box.*

**Late Policy “15 minutes”** Being late greater than 15 minutes will require rescheduling your appointment or waiting until the next available opening. There are no guarantees since openings due to cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient.

**24 Hour Advanced Notice Fee** If you wish to cancel or change an appointment, we request at least **24 hour advanced notice**. Anything less will result in a **\$10 fee** charged to your account. It costs us money to make appointments available to you whether you attend or not (staff wages, rent, etc.) We do not make money with this charge. It merely deters last minute changes. Advanced notice allows someone else (who needs it) the opportunity to reserve that space. Please be courteous and responsible. Thank you.

**All payments are due upon arrival** If you happen to forget your wallet or check book we may still be able to see you, but you will have to fill out an Extension Request. This is a “promise to pay” that carries a minimal fee that allows you to keep your appointment.

**No shows are bad** If you fail to show for an appointment without notification you will be charged a \$25 Fail to Show Fee. You may reschedule appointments again on a ‘first come, first serve’ basis.

**Cellular phone must be shut OFF or silent** We realize that emergency may arise and you need to access your cell phone, however, please be courteous and set it to silent mode or turn it off during the session. If you must make or take a call, we ask you to notify the therapist if necessary and step outside the building.

**All Children require supervision at all times** All children require adult supervision at all times either with a parent or a therapist. It is NOT appropriate to leave children alone in the waiting area and it is NOT SAFE to allow them to roam unsupervised in the treatment rooms. We encourage parents to be in therapy sessions whenever possible. This includes bringing siblings into the room if they can be restrained from disrupting treatment. If clients do not do well with parents in the room or siblings are distracting, you will be asked to stay in the waiting area. Your children are responsible for cleaning up after themselves. Please be responsible.

**Financial Hardship** If you are experiencing difficulties and cannot afford the cost of our services, we have a ‘Financial Hardship’ form you may fill out. If you qualify for financial assistance based on the federal guidelines we may legally assist you by waiving or discounting your patient responsibility portion of the bill. Please ask at the front desk for assistance.

**Important notice from the federal government** It is unlawful to routinely avoid payment of co-pay, deductible and/or coinsurance...even if your doctor allows it. Unless you fill out a Financial Hardship form and qualified based on federal standards you **MUST** pay your responsibility portion as outlined by your insurance. Failure to comply is a violation of the law.

I have read and agree to all the policies. Sign \_\_\_\_\_ Date \_\_\_\_\_

I recognize policies are subject to change at the discretion of ATS Clinics, LLC.

# PATIENT RIGHTS & RESPONSIBILITIES

## You have the right to:

- Express concerns about any aspect of your care without fear of retaliation, and/or utilize the office's own grievance procedures.
- File a complaint with HIPPA.
- Request and receive copies of your medical and billing information.
- Receive considerate and respectful care.
- Receive timely and competent care.
- Verbal and physical privacy as much as reasonably possible.
- Request person of your own gender to be present during a medical exam.
- Expect that your medical information will be protected and accessed by only those people who are directly involved in your case.
- Expect reasonable safety and security while in office.
- To ask questions.
- Receive clear and prompt answers to your health care questions.
- The right to refuse any and all treatments.

## Patient Responsibilities:

- Provide accurate and complete medical information about your child's health.
- To participate in your child's care and in the decision making.
- Ask questions when you do not understand information given to you.
- Follow your doctors orders and instructions.
- Keep appointments, be on time and have the courtesy to call when unable to.
- Review your living will or Durable Power of Attorney and make sure there is a copy on file with all your health care providers.
- Be considerate of the needs and privacy of other patients.
- To know your insurance policy. Patients should be aware of their coverage including which health care providers are contracted with their plan, covered and non-covered benefits, authorization requirements, and cost share information such as deductibles, coinsurance, and co-payments. If you are not familiar with your plan coverage, we recommend you contact your carrier directly.
- To obtain a referral from your Physician and/or obtain authorization for treatment from their insurance carrier prior to receiving services. Any non-covered services are the responsibility of the patient.
- To promptly pay any patient responsibility indicated by their insurance carrier.
- To facilitate in claims payment by contacting their insurance carrier when claims have not been paid.

## Achievement Therapy's Responsibility:

- To provide quality medical care
- To file insurance claims as a courtesy to the patient. A 60 day period will be extended for pending insurance payment, after which the patient may be held responsible for the balance.

## **Our commitment to your privacy**

Achievement Therapy Services, LLC. is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We are also required by law to provide you with this notice of our legal duties and the privacy we maintain in our practice concerning your health information. We realize these laws are complicated, but we must provide the following important information to you. We also reserve the right to amend or revise this Notice of Privacy Practices as necessary.

## **Your rights regarding your health information\_**

The health and billing records we maintain are the physical property of Achievement Therapy Services, LLC.. However, the information in these records belongs to you. You have the right to:

1. Request a restriction of certain disclosures and uses of your health information in writing to our office. We are not required to grant the request but we will comply with any request granted;
  2. Request that you be allowed to inspect and copy your health record and billing record - you may exercise this request by delivering the request in writing to the office;
  3. Appeal a denial of access to your protected health information except in certain circumstances;
  4. Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
  5. File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
  6. Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
  7. Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and
  8. Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.
- If you would like to exercise any of the above rights, please contact Amy Gallagher, owner, in person or in writing. We will assist you in the steps you should take to exercise your rights.

## **Use and disclosure of your health information in certain special circumstances**

The following circumstances may require us to use or disclose your health information:

1. To public health authorities that are authorized by law to collect information;
2. To health oversight agencies for activities authorized by law. These may include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions, civil administrative and criminal procedures or actions, or other monitoring programs of the government;
3. Lawsuits and similar proceedings in response to a court or administrative order;

4. If required to do so by a law enforcement official;
5. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat;
6. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities;
7. To federal officials for intelligence and national security activities authorized by law;

## **NOTICE OF PRIVACY PRACTICES**

**This notice describes how health information about you as a patient of Achievement Therapy Services, LLC. may be used and disclosed and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA). Please review notice carefully.**

8. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official; and
9. For Workers' Compensation and similar programs.

### **Other disclosures and uses**

#### Notification

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

#### Communication with family

Using our best judgement, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

### **Right to a copy of this notice**

You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give a copy of this notice to you at any time.

**Right to file a complaint**

If you believe your privacy rights have been violated, you may file a complaint with Achievement Therapy Services, LLC., or with the Secretary of the Department of Health and Human Services. If you have any questions regarding this Notice of Privacy Practices, please contact:

Achievement Therapy Services, LLC  
Attn: Jeffrey Beran, PT, DPT  
Director of Therapy  
7120 E. Sahuaro Drive North  
Scottsdale, AZ 85254

I hereby acknowledge that I have been presented with a copy of Achievement Therapy Service's Notice of Privacy Practices.

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Signature

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Printed Name of Patient

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Date



**Acknowledgement of  
Achievement Therapy Services, LLC  
Policies**

I have reviewed and understand Patient Rights & Responsibilities, Consent to Treat and Disclose, and Privacy Practices. A copy will be provided upon request of all policies of ATS Clinics, LLC. (Achievement Therapy Services)

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date: \_\_\_\_\_

I understand if I refuse to sign this that Achievement Therapy Services, LLC reserves the right to refuse medical treatment.

Insurance Information						
Patient Name		Birth date	Age	Sex	SS#	
Address		City		State	Zip code	
Home Phone	Diagnoses					
Father		Work Phone	Mother		Work Phone	
Referred by				Case Manager / DDD Assist Number		
Primary Physician					Phone	
<b>Primary Insurance Plan</b>			Employer			
Policy Holder			SS#	Birth date		
Address (if different from patient)			City		State	Zip code
Group #			ID or Policy #			
Send Claims to:					Phone	
Address			City		State	Zip code
<b>Secondary Insurance Plan</b>			Employer			
Policy Holder			SS#	Birth date		
Group #			ID or Policy #			
Send Claims to:					Phone	
Address			City		State	Zip code

### MEDICAL INFORMATION RELEASE

I hereby authorize the release of any information, including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or companies or other health care agencies. I also authorize the release of medical records or copies of such and request that they be transferred to Achievement Therapy Services, LLC. 7120 E. Sahuaro Drive North, Scottsdale, AZ 85254

### FINANCIAL POLICY

I understand and agree that I am ultimately responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due upon demand. I understand that insurance claim forms will be submitted to my insurance company as a matter of convenience. I understand and agree that if it becomes necessary to retain an attorney and/or collection agency for the collection of any outstanding charges, whether or not a lawsuit is filed on my account, I will be responsible for any attorney and/or collection fees and court costs in addition to the outstanding balance. **Patients authorized for therapy by the Arizona Department of Economic Security, Division of Developmental Disabilities, are not responsible for payment of charges.**

### CANCELLATION POLICY

If you need to cancel an appointment, we request a 24-hour notice. If you cancel within less than 24 hours of your scheduled appointment, you may be charged a fee of \$10. If you do not call to cancel and fail to keep your appointment, you will be charged \$25. **Insurance will not pay for such 'no shows' or late cancellation charges - these charges must be paid by the patient.** If you have 2 or more cancellations within a 4-week period, or 2 or more no shows, we reserve the right to discontinue services.

### ASSIGNMENT OF BENEFITS

I request that payment of authorized insurance benefits be made on my behalf to Achievement Therapy Services, LLC.

Signature \_\_\_\_\_ Date \_\_\_\_\_



Occupational  
Physical  
Speech

**Achievement Therapy Services  
(ATS Clinics, LLC)  
Consent for Treatment  
Medical Release**

I, \_\_\_\_\_ (Parent/Guardian), hereby authorize Achievement Therapy and/or its licensed medical professionals and such assistants to render any and all medical care deemed necessary and any additional care and supplies that are recommended for the treatment of \_\_\_\_\_ (child).

**Medical Record Release**

This will authorize Achievement Therapy to release any general, medical, as well as Psychiatric/ Psychological, drug/alcohol, and HIV testing information from my child's health records, per patient's request. I authorize the release of information for exchange between Achievement Therapy Services, LLC., the Division of Developmental Disabilities, the physicians office and school records as they apply to the provision of therapies.

**Third Party Liability**

Achievement Therapy does not believe that a liability case against a third party is reason to delay payment of services. I agree that payment for services rendered is not contingent upon any settlement, judgement, or verdict of which they may eventually recover as a result of such liability cases. I agree to be ultimately responsible for payment in full for all services rendered.

**Assignment of Benefits**

Under qualifying circumstances, I authorize Achievement Therapy to process claims related to my child's personal health or other insurance for covered services rendered to my child. I also assign and authorize payment from said insurance carrier to be paid directly to Achievement Therapy rendered on my child's behalf.

**Circumstantial Risk**

I have been made aware of the possible benefits, effects, and possible risk or complications associated with the care of my child. I agree to accept the treatment prescribed to my child and recognize that I am free to seek other opinions relating to his/her health.

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Signature of Parent/Guardian

Date

I have reviewed the Pre-Service Providers Orientation form for the following child and I understand the personal information it provided.

Client \_\_\_\_\_

Therapist \_\_\_\_\_

Date Reviewed \_\_\_\_\_

Date Updated & Reviewed \_\_\_\_\_

Date Updated & Reviewed \_\_\_\_\_

ARIZONA DEPARTMENT OF ECONOMIC SECURITY  
Division of Developmental Disabilities

**PRE-SERVICE PROVIDER ORIENTATION**

**INSTRUCTIONS:** This form is to be completed by the provider and the individual and/or responsible party receiving services prior to the initiation of services. A copy **MUST** be retained by the provider and a copy sent to the District Office. The provider must also ensure that a General Consent and Authorization form is completed and retained by the provider.

**PROVIDER INFORMATION**

PROVIDER'S NAME (Last, First, M.I.)	EMPLOYER TAX NO.	AHCCCS ID NO.
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IS THERE ANY SPECIAL TRAINING REQUIRED?  
 Yes  No Describe:  
 Med Training Needed  Yes  No Seizure Management Training Needed  Yes  No

**CRITICAL INFORMATION**

INDIVIDUAL'S NAME (Last, First, M.I.)	ASSISTS NO.	BIRTHDATE
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INDIVIDUAL'S ADDRESS (No., Street, City, State, ZIP)

GUARDIAN/RESPONSIBLE PARTY'S NAME (Last, First, M.I.)	RELATIONSHIP	PHONE NO.
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ADDRESS (No., Street, City, State, ZIP)

EMERGENCY CONTACT'S NAME (If other than responsible party)	RELATIONSHIP	PHONE NO.
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SUPPORT COORDINATOR'S NAME	OFFICE LOCATION	PHONE NO.
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NAME OF ALTCS/DDD HEALTH PLAN	AHCCCS ID NO.	PHONE NO.
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PRIMARY CARE PHYSICIAN'S NAME	PHONE NO.
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ADDRESS (No., Street, City, State, ZIP)

URGENT CARE FACILITY'S NAME	PHONE NO.
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ADDRESS (No., Street, City, State, ZIP)

OTHER HEALTH INSURANCE INFORMATION

**DAY PROGRAM (If applicable)**

NAME OF DAY PROGRAM	PROGRAM TYPE	DAYS AND HOURS OF ATTENDANCE	TRANSPORTATION METHOD
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DAY PROGRAM ADDRESS (No., Street, City, State, ZIP)	PHONE NO.
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**HEALTH – MEDICAL**

**CURRENT MEDICATIONS AND SIGNIFICANT HISTORICAL MEDICATION ISSUES:**

MED LOG REQUIRED <input type="checkbox"/> Yes <input type="checkbox"/> No	SPECIAL MEDICATION INSTRUCTIONS
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**ALLERGIES TO:**

Food <input type="checkbox"/> Yes <input type="checkbox"/> No Specify	Medication <input type="checkbox"/> Yes <input type="checkbox"/> No Specify
Bee Stings <input type="checkbox"/> Yes <input type="checkbox"/> No Specify	Other <input type="checkbox"/> Yes <input type="checkbox"/> No Specify

RECOMMENDED RESPONSE TO ALLERGIC REACTION

**SEIZURES:**  Yes  No

DESCRIBE	FREQUENCY	APPROXIMATE DURATION
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RECOMMENDED RESPONSE TO SEIZURE ACTIVITY

**ASSISTIVE DEVICES**

VISION	HEARING	DENTAL APPLIANCES
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**PROTECTIVE DEVICES:**

INSTRUCTIONS FOR USE	PURPOSE
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OTHER INDIVIDUALIZED HEALTH CARE ROUTINES

**PRE-SERVICE PROVIDER ORIENTATION**

INDIVIDUAL'S NAME <i>(Last, First, M.I.)</i>	ASSISTS NO.	BIRTHDATE
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**DIET**

**FOOD:**

INDEPENDENT WITH UTENSILS <input type="checkbox"/> Yes <input type="checkbox"/> No	INDEPENDENT WITH SPECIFIC UTENSILS <input type="checkbox"/> Yes <input type="checkbox"/> No	REQUIRES LIMITED ASSISTANCE <input type="checkbox"/> Yes <input type="checkbox"/> No	REQUIRES SIGNIFICANT ASSISTANCE <input type="checkbox"/> Yes <input type="checkbox"/> No
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DOES FOOD PRESENT A CHOKING HAZARD  
 Yes  No      Required consistency of food     Normal     Chopped     Puréed

SPECIAL DIET

TUBE FEEDING <i>(Special instructions required)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	EATING DISORDER <i>(Describe)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No
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**BEVERAGES:**

INDEPENDENT WITH ANY CUP/GLASS <input type="checkbox"/> Yes <input type="checkbox"/> No	INDEPENDENT WITH ADAPTIVE <input type="checkbox"/> Yes <input type="checkbox"/> No	REQUIRES LIMITED ASSISTANCE <input type="checkbox"/> Yes <input type="checkbox"/> No	REQUIRES SIGNIFICANT ASSISTANCE <input type="checkbox"/> Yes <input type="checkbox"/> No
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INDEPENDENT IN OBTAINING/REQUESTING BEVERAGES  
 Yes  No      Describe adaptive eating/drinking equipment

IF SPECIAL LIQUID INTAKE NEEDS DESCRIBE

SYSTEM FOR FLUID INTAKE *(If applicable)*

**COMMUNICATION**

**COMMUNICATION SKILLS:** *(Check as applicable)*

<input type="checkbox"/> Uses complex Sentences	<input type="checkbox"/> Uses simple sentences	<input type="checkbox"/> Signs	<input type="checkbox"/> Nods yes/no	<input type="checkbox"/> Gestures
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DESCRIBE AUGMENTATIVE COMMUNICATION DEVICES *(If applicable)*

**MOBILITY**

**BALANCE WHILE STANDING**

<input type="checkbox"/> Excellent <i>(not an issue)</i>	<input type="checkbox"/> Moderate <i>(stumbles, etc)</i>	<input type="checkbox"/> Poor <i>(very unsteady; falls)</i>	UTILIZES ADAPTIVE AIDS FOR BALANCE <input type="checkbox"/> Yes <input type="checkbox"/> No
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INDEPENDENT MOBILITY *(Check as applicable)*  
 Crawling/scooting     Kneeling     Standing     Walking     Running     Climbing

MOBILITY/BALANCE AIDS *(Check as applicable)*  
 N/A     Walker     Cane     Crutches     AFOs     Leg Braces     Wheelchair     Other *(Specify)*

POSITIONING INSTRUCTIONS	LIFTING/CARRYING INSTRUCTIONS
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**PERSONAL CARE SKILLS** *(Check all applicable items)*

	DRESSING	TOILETING	BATHING	DENTAL CARE	MENSES	MED. ADMIN.	OTHER
Independent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Requires Prompting/reminding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Requires Limited assistance/ supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Requires significant assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IF APPLICABLE, DESCRIBE SPECIAL PERSONAL CARE NEEDS AND PREFERENCES

**BEHAVIORAL CONCERNS** *(If applicable)* CIT Training     Yes     No

BRIEF DESCRIPTION	APPROXIMATE FREQUENCY	RECOMMENDED INTERVENTION
Aggression		
Self-Injurious Behavior		
Property Destruction		
AWOL		
Self Stimulation		
Sexual Acting Out		
Other		

IS A BEHAVIOR TREATMENT PLAN AVAILABLE FOR ADDITIONAL INFORMATION <input type="checkbox"/> Yes <input type="checkbox"/> No	REASON FOR BTP
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METHOD USED TO OBTAIN INFORMATION (In person, case file, etc)

**SIGNATURES**

SIGNATURE OF PERSON COMPLETING IF NOT RESPONSIBLE PARTY	RELATIONSHIP	DATE
PRINT PROVIDER'S NAME	PROVIDER'S SIGNATURE	DATE
PRINT RESPONSIBLE PERSON/GUARDIAN'S NAME	RESPONSIBLE PERSON/GUARDIAN'S SIGNATURE	DATE