Aspire Therapies, LLC

2851 Stage Village Cove, Suite 2, Bartlett, TN 38134
Phone (901) 949-9488 · Fax (800) 420-3359

Form 1: New Patient Intake & Child History

Please complete one form per child. If a question doesn't apply, leave it blank. Your therapist will go over anything you're unsure about at the evaluation.

Child information

Field	Answer
Child's legal first name	
Middle name	
Last name	
Suffix (Jr., Sr., II, III, other)	
Preferred name / nickname	
Date of birth (MM/DD/YYYY)	
Sex assigned at birth	Select
Primary language spoken at home	
Other languages spoken at home	
Street address	
Apt / suite	
City	
State	
ZIP code	
Daycare or school name	
Grade / classroom	

Parent or legal guardian

Field	Guardian 1	Guardian 2
First name		
Middle name		
Last name		
Relationship to child		
Mobile phone		
Email		

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Field	Guardian 1	Guardian 2
Address: street, apt, city, state, ZIP (if different from child)		
Has legal custody? (Yes / No / Shared)		

If there is a custody or court order that affects who may consent to care or receive information, please provide a copy.

Emergency contact (other than guardians)

Name	Relationship	Phone

Insurance

Field	Primary	Secondary (if any)
Insurance company		
Plan type (Commercial / TennCare / TEIS)		
Member ID		
Group number		
Policyholder name		
Policyholder date of birth (MM/DD/YYYY)		
Policyholder relationship to child		

Please upload a photo of the front and back of each insurance card.

Referring and primary care provider

Field	Answer
Pediatrician / primary care provider	
Practice name	
Practice phone	
Referring provider (if different)	
Services requested	☐ OT ☐ Speech ☐ Both ☐ Not sure
How did you hear about Aspire?	

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Your concerns

1. What are your main concerns about your child's development right now?
2. When did you first notice these concerns?
3. What would you most like your child to be able to do after therapy?
4. Has anyone else (teacher, doctor, daycare) shared concerns? What did they say?

Pregnancy, birth and early development

1. Was your child born full-term? If not, at how many weeks?
2. Any complications during pregnancy, delivery, or a NICU stay?
3. At about what age did your child: sit alone, crawl, walk, say first words, put two words together, become toilet trained?

Medical history

Question	Answer
Diagnoses (e.g. autism, ADHD, Down syndrome, cerebral palsy)	
What have you noticed that led to this OT and/or speech evaluation? (e.g. trouble with handwriting, feeding, sensory needs, coordination, talking or being understood)	

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Question	Answer
Who else has noticed these concerns? (check all that apply: parent/guardian, primary care provider, teacher, daycare staff, other) What did they share, and when were the concerns first noticed?	
Current medications	
Allergies (food, medication, latex, other)	
Hearing tested? Date and result	
Vision tested? Date and result	
Seizures, heart, or breathing conditions	
Surgeries or hospital stays	
Ear infections or ear tubes	
Any dietary restrictions	

Past and current services

1. Has your child had OT, speech, PT, ABA, or developmental therapy before? Where, and when?

2. Does your child have an IFSP (TEIS), IEP, or 504 plan? Please upload a copy if you have one.

3. Any past evaluations? Please upload copies.

Daily life (check any that are a concern)

- ☐ Feeding or picky eating
- ☐ Sleep
- ☐ Dressing, bathing, or toileting
- ☐ Handwriting or using utensils, crayons, scissors
- ☐ Balance, coordination, or clumsiness

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- ☐ Reacting strongly to noise, touch, textures, or movement
- ☐ Following directions
- ☐ Being understood by others
- ☐ Understanding what others say
- ☐ Stuttering
- ☐ Playing with other children
- ☐ Behavior, meltdowns, or transitions

Your child, in your words

1. What does your child love? Favorite toys, activities, characters, or rewards?

2. What helps your child feel calm when upset?

3. Anything else you'd like your therapist to know?

Completed by (name) **Relationship**

Date

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Form 2: HIPAA Privacy Acknowledgment & Communication Preferences

Acknowledgment of Notice of Privacy Practices

I acknowledge that I have been offered a copy of Aspire Therapies, LLC's Notice of Privacy Practices. It explains how my child's health information may be used and shared, and my rights regarding that information. A copy of the notice is available at the front desk at any time.

How may we contact you?

Please check every way we may contact you about appointments, billing, and your child's care.

Method	Phone number or email address	OK to leave details?
Mobile phone call		☐ Yes ☐ Name and callback only
Text message (appointment reminders)		☐ Yes ☐ No
Email		☐ Yes ☐ No
Home phone / voicemail		☐ Yes ☐ Name and callback only

Standard email and text messages may not be fully secure. By allowing email or text, I accept that risk for the messages I choose to receive this way. I may change these preferences at any time.

To choose who may pick up your child or receive information about their care, see Form 9.

Parent/guardian signature _____

Printed name _____ **Date** _____

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Form 3: Consent to Evaluate and Treat — Occupational Therapy

If your child receives both occupational therapy and speech therapy at Aspire, please complete and sign both Form 3 and Form 4.

Child's name _____ Date of birth _____

I give permission for Aspire Therapies, LLC's licensed occupational therapists (OTR/L) to evaluate my child, and for Aspire's occupational therapists and certified occupational therapy assistants (COTA), working under an occupational therapist's supervision, to treat my child.

I understand that:

1. **The evaluation** is completed by a licensed occupational therapist (OTR/L). It may include standardized testing, observation, play-based activities, and questions for me about my child's development and daily routines.
2. **Treatment** is based on a plan of care with goals my therapist and I set together. It may be provided by an occupational therapist or a COTA, and may include fine motor, handwriting, sensory processing and regulation, self-care, feeding, motor planning, and coordination activities.
3. **Therapy is hands-on.** It can involve physical contact (such as hand-over-hand guidance or movement on therapy equipment), swings, climbing, and other sensory gym equipment, always with appropriate supervision.
4. **Feeding therapy**, if recommended, may involve introducing new foods and textures. I may be asked to bring certain foods from home or from outside Aspire for my child's sessions. I will tell my therapist about all allergies and dietary restrictions.
5. **Services are provided** at Aspire's Bartlett clinic or at my child's daycare. Aspire does not provide home visits.
6. **Results are not guaranteed.** Progress depends on many factors, including attendance and practice at home. **PLAY WITH YOUR CHILD!**
7. **My child's plan of care** may be shared with my child's referring provider and insurance company as required for treatment and payment.
8. **I may ask questions,** refuse any activity, or withdraw this consent at any time by telling my therapist or Aspire in writing.

This consent stays in effect for the length of my child's care at Aspire unless I withdraw it in writing.

Parent/guardian signature _____

Printed name _____ **Relationship** _____

Date _____

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Form 4: Consent to Evaluate and Treat — Speech-Language Therapy

If your child receives both occupational therapy and speech therapy at Aspire, please complete and sign both Form 3 and Form 4.

Child's name _____ Date of birth _____

I give permission for Aspire Therapies, LLC's licensed speech-language pathologists (SLP) to evaluate and treat my child.

I understand that:

1. **The evaluation** may include standardized testing, a speech and language sample, a feeding observation, an oral-motor screening, observation during play, and questions for me about my child's communication at home.
2. **Treatment** is based on a plan of care with goals my therapist and I set together. It may include speech sounds and articulation, expressive and receptive language, early communication, social communication, fluency, and strategies to use at home.
3. **An oral-motor examination** may involve looking at my child's mouth, lips, and tongue, sometimes using a gloved hand or tongue depressor.
4. **A hearing screening** or referral to an audiologist may be recommended if hearing could affect my child's speech or language.
5. **Services are provided** at Aspire's Bartlett clinic or at my child's daycare. Aspire does not provide home visits.
6. **Results are not guaranteed.** Progress depends on many factors, including attendance and practice at home. **PLAY WITH YOUR CHILD!**
7. **My child's plan of care** may be shared with my child's referring provider and insurance company as required for treatment and payment.
8. **I may ask questions,** refuse any activity, or withdraw this consent at any time by telling my therapist or Aspire in writing.

This consent stays in effect for the length of my child's care at Aspire unless I withdraw it in writing.

Parent/guardian signature _____

Printed name _____ **Relationship** _____

Date _____

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Form 5: Professional Relationship with Your Child's Therapists

We care about your family, and we want our relationship with you to stay professional, so every child gets fair, focused care. These guidelines help us do that.

1. **Communication goes through Aspire.** Please contact your therapist through Aspire's phone line, or approved email, not personal phone numbers or personal social media.
2. **Social media.** Our therapists don't connect with families on personal social media accounts while a child is in care. This protects your privacy and theirs.
3. **Gifts.** A thank-you is always kind, but never expected.
4. **Outside work.** Therapists can't provide babysitting, private sessions, or other paid services to Aspire families outside of Aspire.
5. **Questions and concerns.** You're always welcome to talk with your child's therapist. If a concern isn't resolved, please contact Whitney Joy Sanford, OTR/L, Owner, at (901) 562-3915 or wjoy@aspiretherapiesllc.com.
6. **Respect goes both ways.** We ask that families treat staff with the same respect we show every child and family. Aspire may end services if a family member is abusive or threatening toward staff or other families.
7. **Supervision during sessions.** During the evaluation, parents are very strongly encouraged to stay and take part. During treatment sessions you're always welcome to stay, but most children focus best one-on-one with their therapist, without distractions, so you're also welcome to wait in our lobby. Please stay reachable by phone during your child's entire session.
8. **Safety of our therapists.** Aspire reserves the right to discharge a child from services if the child becomes overly aggressive or injures a therapist. When possible, we'll talk with you first about a plan and help with a referral to another provider.

I have read and agree to these guidelines.

Parent/guardian signature _____

Printed name _____ **Date** _____

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Form 6: Client & Family Rights Acknowledgment

We are honored to provide therapy services to your child and family. As a family receiving our services, you and your child have the following rights:

1. **To be treated with dignity and respect** by every person at Aspire Therapies, LLC, in every setting where services are provided.
2. **To person-centered services** designed around your child's and family's goals, values, and priorities. You are a partner in your child's care.
3. **To take part in goal setting.** Your priorities and knowledge of your child are essential to planning.
4. **To informed consent.** You'll receive complete, honest information about any evaluation, therapy approach, or service before it begins, in language you understand. You may give or withhold consent freely and withdraw it at any time.
5. **To access your child's records.** You may review and receive a copy of your child's therapy records. Contact Whitney Joy Sanford to request them.
6. **To privacy and confidentiality.** Your child's information is protected under HIPAA and Aspire's confidentiality policies. It won't be shared without your written permission, except as required by law.
7. **To be free from abuse, neglect, mistreatment, and exploitation** by any Aspire staff member, contractor, or visitor. Report any concern right away to Whitney Joy Sanford or to the Tennessee Child Abuse Hotline: **1-877-237-0004**.
8. **To culturally responsive services** that respect your family's culture, language, religious beliefs, and community values.
9. **To file a grievance** and receive a timely response, without fear of retaliation or any effect on your child's services.
10. **To withdraw from services** at any time, for any reason, without penalty.

To exercise any of these rights, file a grievance, or ask a question: Whitney Joy Sanford, OTR/L, Owner · (901) 562-3915 · wjoy@aspiretherapiesllc.com

Outside complaint resources

- Tennessee Department of Health, Office of Investigations (complaints about any licensed occupational therapist, occupational therapy assistant or speech-language pathologist): 1-800-852-2187
- TEIS Parent Rights Information: 1-800-852-7157
- Tennessee Voices for Children: 1-800-670-9882

I have received and reviewed the Aspire Therapies, LLC Client and Family Rights Statement.

Parent/guardian signature _____

Printed name _____ **Date** _____

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Form 7: Attendance & Cancellation Policy

Consistent attendance is one of the biggest drivers of your child's progress. Each session is reserved just for your child, and many families are waiting for openings, especially after-school times.

1. **Cancel at least 24 hours ahead** by calling (901) 949-9488. Leave a message if no one answers.
2. **Late arrivals.** If you arrive more than 15 minutes late, your child's session may be shortened or rescheduled so the next child's session stays on time.
3. **Illness.** Please keep your child home with a fever, vomiting, diarrhea, or a contagious illness in the last 24 hours. Please give us as much notice as possible if your child is not able to keep their appointment.
4. **No-shows.** A missed session without notice counts as a no-show.
5. **Repeated absences.** After 3 no-shows or 3 late cancellations in 30 days, Aspire may move your child's standing appointment to an open time or end services, and refer you to another provider.
6. **$50 no-call/no-show fee** for commercial-insurance families. This applies to a missed appointment with no call, or a cancellation within 1 hour of the appointment time. TennCare (Medicaid) and TEIS families are never charged this fee or any other charge.
7. **When Aspire cancels.** If your therapist is out, we'll contact you as early as possible and offer a makeup session when we can.
8. **Pickup.** Please be back in the lobby by the end of your child's session.

I have read and agree to the attendance and cancellation policy.

Parent/guardian signature _____

Printed name _____ **Date** _____

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Form 8: Financial Policy & Card-on-File Authorization

For families with commercial insurance only. Families covered by TennCare or TEIS skip this form. Aspire accepts TennCare (Medicaid) through BlueCross BlueShield, UnitedHealthcare, and WellPoint. TennCare and TEIS have no out-of-pocket costs for covered services, and Aspire will never ask those families for a card.

Financial policy

1. **We bill your insurance for you.** Aspire is in network with BlueCross BlueShield and UnitedHealthcare commercial plans.
2. **We check your benefits before every visit** and tell you what we expect you to owe. This is an estimate. Your insurance makes the final decision.
3. **What you may owe:** copays, coinsurance, and any amount that applies to your deductible, as shown on your insurance company's Explanation of Benefits.
4. **Copays are expected at the time of service.** Coinsurance and deductible amounts are billed after your insurance processes the claim, for only the patient amount your insurance says you owe.
5. **Receipts:** you'll get an emailed receipt for every charge.
6. **Changes in coverage.** Please tell us right away about any insurance changes, so we can verify your new benefits and still see your child on the day of service.
7. **Questions about a charge?** Call (901) 949-9488 within 60 days of the charge and we'll review it with you.

Card-on-file authorization

Card details are entered securely through Stripe, Aspire's payment processor, by our front desk team. **Never write a card number on this form.** Aspire does not store your full card number.

I authorize Aspire Therapies, LLC to keep my card on file for my child's copays, coinsurance, deductibles, other patient balances as determined by my insurance, and the no-call/no-show fee described in Form 7. **Aspire will contact me for my permission before processing each payment.** This authorization stays in effect until I cancel it in writing or by phone. Canceling does not cancel any balance already owed.

Field	Answer
Child's name	
Cardholder name	
Last 4 digits of card (filled in by Aspire)	
Cardholder email for receipts	

Cardholder signature _____ **Printed name** _____

Date _____

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Form 9: Authorization to Exchange Information

Working with the other people in your child's life, like their doctor, teacher, or daycare, helps us coordinate care. This form lets you choose who we may share information with. Sharing with your child's referring provider and insurance company for treatment and payment does not need this form.

Child's name _____ Date of birth _____

Part A: Family members and friends

List anyone (grandparents, relatives, friends, babysitters) who may pick up your child or receive information about your child's care. Name, relationship, and phone number are required for each person. Staff may ask for photo ID at pickup.

Name (required)	Relationship (required)	Phone (required)	May pick up child?	May receive information?
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

Information that may be shared with these family members and friends (check all that apply):

- ☐ Appointment times and attendance
- ☐ General progress updates
- ☐ Home practice activities
- ☐ Billing and balance information
- ☐ Full therapy records

Part B: Professionals and other clinicians

I authorize Aspire Therapies, LLC to exchange information about my child with these professionals (doctors, teachers, daycare staff, other therapists and clinicians):

Person or organization	Role (doctor, school, daycare, other therapist)	Phone	Email	Share	Receive
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No

Information that may be shared with professionals and other clinicians (check all that apply):

- ☐ Evaluation reports
- ☐ Plan of care and goals

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- ☐ Progress notes and updates
- ☐ Attendance
- ☐ IEP, IFSP, or 504 plan documents
- ☐ Verbal conversations about my child's care

Purpose: coordination of my child's care and education.

This authorization expires on _____

or one year from the date signed, whichever comes first.

I understand that:

1. I may revoke this authorization at any time in writing, except for information already shared.
2. Signing is voluntary. My child's treatment, payment, or eligibility for services does not depend on it.
3. Information shared with someone not covered by HIPAA (such as a daycare) may no longer be protected by federal privacy law.
4. I may receive a copy of this form.

Parent/guardian signature _____

Printed name _____ **Relationship** _____

Date _____

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Form 10: Photo & Video Release (Optional)

This form is optional. Saying no has no effect on your child's care.

Part A: For your child's therapy

Therapists sometimes take photos or short videos during sessions to track progress, such as handwriting samples or how a child moves on equipment. These stay in your child's secure record and are never shared publicly.

- ☐ Yes, Aspire may take photos and videos of my child for therapy and progress tracking.
- ☐ No, please don't take photos or videos of my child.

Part B: For Aspire's website and social media

With your permission, Aspire may share photos or videos of your child on our website, Facebook, or other marketing. We will never include your child's last name, diagnosis, or any health information.

- ☐ Yes, Aspire may use photos and videos of my child in its website and marketing.
- ☐ Yes, but only photos where my child's face can't be seen.
- ☐ No, please don't use my child's image in marketing.

I may withdraw this permission at any time in writing. Aspire will stop using my child's image in new materials, but may not be able to remove items already printed or shared.

Parent/guardian signature _____

Printed name _____ **Date** _____