Speech, OT, & Tutoring
aatherapyworks@yahoo.com
734-369-6002

www.a2therapyworks.com
3200 W Liberty Rd, Suite F
Ann Arbor, MI 48103

WELCOME TO A2 THERAPY WORKS

A2 Therapy Works, LLC is a diverse and highly regarded pediatric and young adult private practice that offers quality, family-friendly, and collaborative services to help children, young adults, and families reach their greatest potential. In order to make it easier on busy families, we provide our services at our Ann Arbor clinic, your child's school, or in the comfort of your home.

Our practice provides individual and group treatment to children of all ages with Autism Spectrum Disorder, Articulation Disorders, literacy difficulties, Oral-Motor Dysfunction, Feeding Disorders, Dyspraxia, Language Delays and disorders, Auditory Processing Disorders, Developmental Coordination Disorder and coordination challenges, fine motor and handwriting challenges, difficulty with self-care and activities of daily living, Sensory Processing Disorders and sensory integration challenges, motor planning challenges, emotional regulation challenges, social skill deficits, those in need of Augmentative and Alternative Augmentative Communication (AAC) and more! We work with the following therapy techniques: Phonographix Reading and Spelling Program, The Alert Program, Lindamood Bell, SOS Approach to Feeding, PROMPT, TALK TOOLS, Learning Without Tears, Beckman Oral Motor Therapy, The Zones of Regulation, DIR Floortime, Social Thinking, and more!

We do not have the internal structure to accept all private or public insurance policies. We accept Blue Cross Blue Shield (BCBS) and Blue Care Network (BCN). If you are out of network, we are happy to cooperate with you in seeking reimbursement from your insurance company by providing you the documents to submit to your insurance company. It is your responsibility contact your insurance company to ensure reimbursement for services. We are also willing to write treatment plans for or converse with an insurance representative when necessary. **It is the client's responsibility to check with their insurance company prior to the appointments to determine coverage and reimbursement. Each client is solely and individually responsible for all fees for services provided. If an insurance company does not pay for service, it is ultimately the client's responsibility.**

Please complete the following intake packet and send it to your clinician prior to your initial session. Additionally, please send copies of any speech-language, occupational, or educational reports you have previously received. If you have any questions, please don't hesitate to call. We look forward to working with you!

Sincerely,
Andrea Rich, MA, CCC-SLP, *Speech Language Pathologist*
Director, A2 Therapy Works, LLC

Please fill out and return all following forms to:
A2 Therapy Works, LLC
3200 W Liberty, Suite F
Ann Arbor, MI, 48103
Fax: 734-527-6024
Email: aatherapyworks@yahoo.com
We will contact you to schedule your first appointment.

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UNDERSTANDING INSURANCE

It is your responsibility to be informed of your insurance benefits prior to your initial visit. Contacting the insurance company directly will help you understand your plan and how benefits may be applied. Below you will find helpful information to have on hand, as well as questions to ask:

INFORMATION YOU MAY NEEED WHILE SPEAKING TO INSURANCE

A2 THERAPY WORKS TAX ID: 473343861 **NPI TYPE 2:** 1144608456

ADDRESS: 3200 W. Liberty Suite F, Ann Arbor Michigan, 48103 **FAX:** 734-527-6024

- What are my in-network benefits for speech, occupational, or physical therapy?
- Do I need pre-authorization for these services?
- Do I need a physician referral for these services?
- What is my deductible?
- Has my child/our family met the deductible?
- What is my co-pay or co-insurance?
- Do I only pay one co-pay if I have more than one service in a day?
- What is my annual limit for these services?
- How many therapy visits are covered per year? Is there a combined benefit between speech, occupational, or physical therapy (e.g., 30 visits covered, but they must be divided between speech and occupational therapy)?
- Are any diagnoses excluded that I should be aware of?
- Is A2 Therapy Works in network?

Be sure to note the date and the name of the person you spoke with.

COMMUNICATION EXCHANGE CONSENT

I, _____ (name of responsible party), give my permission to A2 Therapy Works, LLC to exchange information with the following physicians, programs, or other persons (please list name, phone, and email):

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

about _____ (patient's name) whose date of birth is _____.
I also give my permission for A2 Therapy Works, LLC, to provide evaluation reports, treatment notes, and consultative services to the above mentioned client.

_____ _____

Signature of Responsible Party Date

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CLIENT INFORMATION 1 of 2

CLIENT'S NAME

MAILING ADDRESS

EMAIL ADDRESS

DATE OF BIRTH

AGE SEX

RESPONSIBLE PARTY

PRIMARY INSURANCE CARD HOLDER'S DOB

RESPONSIBLE PARTIES RELATIONSHIP TO CLIENT

PHONE

REFERRED BY

NAME OF HEALTH CARE INSURANCE PROVIDER

INSURANCE PHONE

PHYSICIAN'S NAME

MAILING ADDRESS

PRACTICE

PHONE

FAX

HAS YOUR CHILD EVER BEEN GIVEN A MEDICAL DIAGNOSIS? IF YES, PLEASE LIST BELOW

IS YOUR CHILD CURRENTLY TAKING ANY MEDICATION? IF YES, PLEASE LIST BELOW

DOES YOUR CHILD HAVE ANY ALLERGIES OR SPECIAL DIET? IF YES, PLEASE LIST BELOW

DOES YOUR CHILD HAVE NORMAL VISION AND HEARING? PLEASE DESCRIBE BELOW

PLEASE PROVIDE INFORMATION ABOUT YOUR CHILD IN ALL AREAS INDICATED BELOW

PREGNANCY AND DELIVERY

GROSS MOTOR DEVELOPMENT (E.G., WHEN YOUR CHILD BEGAN SITTING INDEPENDENTLY, CRAWLING, WALKING)

LANGUAGE DEVELOPMENT (E.G., WHEN YOUR CHILD BEGAN BABBLING, SAID FIRST WORDS, STARTED COMBINING WORDS)

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CLIENT INFORMATION 2 of 2

PLEASE PROVIDE A BRIEF FAMILY HISTORY

WHAT LANGUAGES DOES YOUR CHILD SPEAK?

PLEASE LIST YOUR PRIMARY CONCERNS ABOUT YOUR CHILD

PLEASE LIST ANY OTHER USEFUL OR IMPORTANT INFORMATION

DOES YOUR CHILD SNORE?

DOES YOUR CHILD HAVE ANY TROUBLE BREATHTING?

DOES YOUR CHILD WAKE UP UN-REFRESHED?

PLEASE LIST YOUR CHILD'S STRENGTHS, FAVORITE ACTIVITES, ETC.

PLEASE LIST OTHER HEALTH CARE PROFESSIONALS CURRENTLY WORKING WITH YOUR CHILD
PLEASE INCLUDE NAMES AND PHONE NUMBERS

NAME AND ADDRESS OF YOUR CHILD'S SCHOOL

PLEASE LIST PREFERRED DAYS FOR THERAPY AND TIMES
WE WILL DO OUR BEST TO FIT YOUR NEEDS

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TERMS OF PAYMENT AGREEMENT

A2 Therapy Works does not bill most insurance companies directly. **It is the client's responsibility to check with their insurance company prior to the appointments to determine coverage and reimbursement.** Additionally, it is important that you receive a prescription from your pediatrician for services before the first session.

At the time of service, each client is solely and individually responsible for all fees for services provided. If an insurance company does not pay for services because services are out-of-network, your deductible has not yet been met, coverage is denied due to lack of referral, a denial of health plan authorization occurs, services are not benefits of your health plan, or any other denial occurs, payment is ultimately the client's responsibility and the client will be responsible for the amount billed. _____ (initial here)

At the time of service, each client is solely and individually responsible for any and all co-payment or co-insurance fees that insurance does not cover. _____ (initial here)

If you have insurance, we will help to verify your coverage for our services. However, it is your responsibility to know what your insurance company covers and what it does not cover. Different plans and employers may result in different benefit provisions; it is up to the client to determine if services are covered under their particular insurance plan. _____ (initial here)

Please Inform us immediately if any part of your insurance coverage changes. Often insurance companies require pre-approval or authorization. They may not retro-date authorizations, which may result in a period in which you are personally responsible for payment for services. _____ (initial here)

Prior to your initial session, we will bill twenty dollars ($20.00) for an initial set up fee. _____ (initial here)

I, _____ (name of responsible party), acknowledge and accept full and complete responsibility for prompt payment of all services rendered to _____ (patient's name) by A2 Therapy Works, LLC. My medical insurance company is _____. In the event that my health plan does not pay for any portion of such services, I understand and agree that I will be responsible for payment in full of all fees due to A2 Therapy Works, LLC at the time of service. I understand that health insurance policies and reimbursement are between myself and my health insurance company, and that all services completed by A2 Therapy Works, LLC for the benefit of the above referenced individual are charged directly to me. I understand that I am responsible for the initial set up fee, and will be responsible for any future cancellation fees should I fail to adhere to the cancellation policy (see details on cancellation policy on following page). I understand that I will be responsible for all legal fees and collection fees which A2 Therapy Works, LLC may incur if payment is not made in accordance with the terms and conditions hereinabove. I acknowledge that I have received written explanation of the fee schedule and the cancellation policy, and, as such, I hereby agree to the above terms and conditions.

Print Name of Responsible Party	Print Name of Patient
Signature of Responsible Party	Date

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CREDIT CARD AUTHORIZATION

We request a card on file for all clients. I, _____ (name of responsible party), give my permission to A2 Therapy Works, LLC to automatically make charges to my credit card on file for payment of speech, occupational, or physical therapy services, and/or associated expenses (i.e., set up fee, late fee, co-pay fees, co-insurance fees, if deductible has not yet been met, if services are out-of-network, if coverage is denied due to lack of referral, if denial of health plan authorization occurs, if services are not benefits of health plan, or if any other denial occurs).

CREDIT CARD NUMBER
WE PREFER VISA OR MC _____ EXPIRATION DATE _____

3 DIGIT CODE _____ NAME AS IT APPEARS ON THE CARD _____

BILLING ADDRESS _____ PLEASE NOTE CARD TYPE BELOW

_____ VISA MASTER CARD

_____ OTHER:

_____ IS THIS A HEALTH SAVINGS ACCOUNT CARD?

_____ YES NO

_____ _____
Signature of Responsible Party Date

CANCELLATION POLICY AGREEMENT
Cancellation Line: (734) 369-6002

I am responsible for attending my speech and language therapy or occupational therapy sessions as scheduled. I understand that I must maintain at least an 80% attendance rate as measured within a given 3-month period or risk losing my appointment spot. _____ (initial here)

In the event of a cancellation, I will provide as much notice as possible. “Non-emergency” cancellations require 24 hours notice and include vacations, pre-planned medical appointments, family events, parties, sporting events, lack of babysitter or anything that is not designated as “emergency.” If the session is not canceled within 24 hours notice I understand I will be responsible to pay a $30 cancellation fee for the missed session. “Emergency” cancellations are accepted only for illness (fever within the last 24 hours, strep, unidentified rash, diarrhea, vomiting, or any contagious illness), illness of a family member, or death in the family. In the event of an emergency cancellation, I understand that I still must notify the clinic on the day of the appointment to avoid a cancellation fee of $30. After 3 emergency cancellations, I understand that a $30 charge will be incurred for all subsequent emergency cancellations within a calendar year. _____ (initial here)

_____ _____
Signature of Responsible Party Date