12580 Old Seward Hwy.
Anchorage, AK 99515
Phone: 907-301-4588
Fax: 866-554-1366

PATIENT INTAKE FORM

PATIENT INFORMATION		
First Name:	Middle:	Last:
Date of Birth:	Age:	Gender:
Primary Care Provider (PCP):		Last Visit:
PCP Address:		PCP Phone Number:
Referred By:		
RESPONSIBLE PARTY INFORMATION		
First Name:	Middle:	Last:
Address:	City:	State & Zip:
Moblie Phone:	Home Phone:	Work Phone:
Email:	Date of Birth:	Employer:
ADDITIONAL PARENT/GUARDIAN INFORMATION		
First Name:	Middle:	Last:
Address:	City:	State & Zip:
Mobile Phone:	Home Phone:	Work Phone:
Email:	Date Of Birth:	Employer:
PRIMARY INSURANCE (Please provide your ID card)		
Insurance Company:	Subscriber ID:	Group ID:
Insured/Relationship:	Employer:	
SECONDARY INSURANCE (Please provide your ID card)		
Insurance Company:	Subscriber ID:	Group ID:
Insured/Relationship:	Employer:	
_____ **I DO NOT HAVE ANY OTHER INSURANCE COVERAGE FROM ANY OTHER SOURCE OTHER THAN THE ABOVE MENTIONED**		
Signature of Responsible Party:		Date:
Print Name:		Driver's License #:
Relationship to Client:		
Social Security Number:		

Social Security Number is not required to receive services, however,

you will be required to pay prior to services being rendered.

READINGWRITE ALASKA

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Child's Name: _____
Child's DOB: _____

PATIENT HISTORY

Check any of the factors listed below that apply:

During Pregnancy:

____ X-Ray treatment
____ RH incompatibility
____ Drug/alcohol use
____ Medications
____ Trauma/injury
____ Other:_____

If adopted

Age of adoption:_____
Is the child aware of adoption: ☐ Yes ☐ No

Labor and Delivery:

____ Full term
____ Premature: _____ weeks early
____ Birth Weight _____lbs _____oz
____ Normal Delivery
____ Induced
____ Cesarean
____ Other:_____

Conditions After Birth:

____ Low APGARS
____ Breathing difficulties
____ Oxygen:_____days/weeks
____ Ventilator:_____days/weeks
____ Sucking/feeding difficulties
____ Seizures
____ Jaundice

____ Bleeding in brain (intraventricular hemorrhage)
____ Heart Problems
____ Persistent Pulmonary Hypertension
____ Other:_____
_____

Current Medication:

(Please list names & reasons for use)

_____
_____
_____
_____

Medical History since Birth:

____ Colic
____ Multiple ear infections/tubes
____ Tonsillitis and/or tonsils/adenoids removed
____ Seizures
____ Encephalitis
____ Meningitis
____ Allergies:_____
____ Heart Problems
____ Asthma
____ Respiratory Problems:_____
____ Intubation/ventilation
____ Chronic colds
____ Exposure to second hand smoke
____ Sepsis
____ Renal (kidney) problems
____ Rubella
____ Toxoplasmosis
____ Feeding problems
____ Cleft lip of palate/craniofacial malformation
____ Reflux
____ Head trauma/brain injury
____ Specific diagnosis(es)/ syndromes:

Other:_____
_____

Current on immunizations ☐ Yes ☐ No

Hearing Evaluated/Screened ☐ Yes ☐ No
Where:_____
Results:_____
_____

Were Developmental Milestones (i.e. speech, walking crawling) met : on time ☐ delayed ☐
If delayed please describe concerns:

_____
_____
_____

Form Completed by:_____ **Date:**_____

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Child's Name: _____

Child's DOB: _____

PROGRAMS/AUTHORIZATIONS

List the names of the Programs and people that have worked with your child. Please send latest Evaluation(s) and/or IEP for your child.

Services	Programs	Teacher/Therapist	Dates
Pediatrician/Physician			
Preschool			
School			
Speech Therapist			
Occupational Therapist			
Physical Therapist			
Counselor/psychologist			
Other			

AUTHORIZATION AND CONSENT FOR TREATMENT, PAYMENT AND OPERATIONS:

Please initial the following boxes:

_____ **I have checked with my insurance company prior to this therapy visit and assert that I have obtained the necessary information regarding the limits of coverage, co-pays and co-insurance.**

_____ **I hereby give Reading Write Alaska permission to evaluation and treat my child, and understand there will be written, oral, and electronic communication between care providers/physicians, insurance companies, and Reading Write Alaska staff. I understand that all practices of confidentiality will be followed with regard to the information provided.**

_____ **I give Reading Write Alaska permission to submit bills directly to the insurance carrier.**

_____ **I authorize any prior or present treating physician, therapist, school, or other health institution to release medical records to Reading Write Alaska if needed for treatment planning.**

_____ **I acknowledge that I have viewed, read, and understand the HIPAA Policy and have been informed of my rights as a patient.**

_____ **I acknowledge I have read and agree to follow Reading Write Alaska's office and financial policies.**

_____ **I acknowledge Reading Write Alaska is only responsible for our clients during the 45 minutes they are in session with us. Drop off and pick up to and from the sessions is the responsibility of the guardian.**

_____ _____

Signature of Parent/Guardian **Date**

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Child's Name: _____

Child's DOB: _____

DEMOGRAPHIC INFORMATION/EDUCATIONAL HISTORY

Family Residing in the Home:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Primary Language Spoken in the House

_____

Family History of Reading/Writing Problems:

_____

_____

_____

Has your child ever been diagnosed with or shown characteristics of ADD/ADAD? ☐ Yes ☐ No

Does your child have an IEP or 504 Plan: ☐ Yes ☐ No

Any psychological testing? ☐ Yes ☐ No

Education:

School Child Attends:

_____

Likes School? ☐ Yes ☐ No

Current Grade: _____

Ever Been Retained: ☐ Yes ☐ No

Has a teacher expressed concerns about your childs learning or behaviors: ☐ Yes ☐ No

If yes please describe:

_____

_____

_____

_____

Does your child have any special needs or require special classroom placement? ☐ Yes ☐ No

Does your child have any cognitive delays? (i.e. known IQ below 70) ☐ Yes ☐ No

Has your child ever been diagnosed with TBI, Brain tumor, Seizures or Autism?

_____

Briefly Describe Your Child's Educational History:

_____

_____

_____

_____

_____

Form Completed by:_____ **Date:**_____

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EMERGENCY CONTACT INFORMATION

If we are unable to reach you and a situation arises, you are authorizing the following contacts to act on your behalf.

Name:_____ Phone:_____ Relationship to patient:_____

Name:_____ Phone:_____ Relationship to patient:_____

CUSTODY POLICY ACKNOWLEDGEMENT

FAMILIES THAT ARE SEPARATED, DIVORCE OR UNMARRIED:
We do not allow more than one responsible party. Parents/Guardians are expected to make arrangements between themselves if they plan to split the charges for treatment. (e.g. we cannot collect half of the current charges and bill the reminder to the other parent/guardian).

*** Custody Arrangements.**

❑ Check this box if you have court ordered custody arrangements.

ACKNOWLEDGEMENT OF PRIVACY NOTICE (HIPAA)

By my signature below, I acknowledge I have received RWA's Notice of Privacy and clients rights and that I understand and have had the opportunity to ask questions about the notice.

Signature:_____ Date:_____

COLLECTION AND PAST DUE ACCOUNTS

We communicate with our families to resolve past due accounts in all cases. If an account is 60 days past due, the parent/guardian will receive a written notice of delinquency. Any account over 90 days past due will be sent to a professional collection agency. Once the account is placed with a collections agency, we cannot take the account back. Please let us know when or if your client contact information changes so we can always reach you.

By my signature below, I acknowledge I have received RWA's past due policy.

Signature:_____ Date:_____

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Warning Signs of Dyslexia or a Struggling Reader
Please check off all that apply:

If a child has 3 or more of the following warning signs, encourage that child's parents and teachers to learn more about Dyslexia.

In Preschool:

[ ] Delayed speech
[ ] Mixes up the sounds and syllables in long words.
[ ] Severe reactions to childhood illnesses
[ ] Constant confusions of left versus right.
[ ] Late establishing a dominant hand
[ ] Difficulty learning to tie shoes
[ ] Trouble memorizing their address, phone number, or the alphabet
[ ] Can't create words that rhyme.
[ ] Has a close relative with Dyslexia

In Elementary School:

[ ] Dysgraphia (slow, non-automatic handwriting that is difficult to read)
[ ] Letter or number reversals continuing past the end of the first grade.
[ ] Extreme difficulty learning cursive
[ ] Slow, choppy, inaccurate reading
- Guesses base on shape or context
- Skips or misreads prepositions (at,to,of)
- Ignores suffixes
- Can't sound out unknown words.

[ ] Terrible spelling
[ ] Often can't remember sight words ("they", "were", "does") or homonyms ("their", "they're", and "there")
[ ] Trouble with math
- Memorizing math facts or multiplication tables
- Memorizing a sequence of steps
- Directionality

[ ] Difficulty telling time on a clock with hands
[ ] When speaking, difficulty finding the correct word
- Lots of "whatyamacallits" and "thingies"
- Common sayings come out slightly twisted

[ ] Extreme messy bedroom, backpack, and desk
[ ] Dreads going to school
- Complains of stomach aches or headaches
- May have nightmares about school

[ ] Difficulty copying off the board
- Can only copy one or two letters at a time
- Often loses his place when copying
- Makes mistakes when copying

[ ] Difficulty with near point copying
- can only copy one or two letters at a time
- often loses his place when copying
- makes mistakes when copying

Please check off all that applies for your family history:

[ ] Limited vocabulary
[ ] Extremely poor written expression
- Large discrepancy between verbal and written compositions.

[ ] Unable to master foreign language
[ ] Difficulty reading printed music
[ ] Poor grades in many classes
[ ] May drop out of high school
[ ] Slow reader
[ ] May have to read a page 2 or 3 times to understand it.
[ ] Difficulty putting thoughts onto paper
- Dreads writing memos or letters

[ ] Still has difficulty with right vs. left
[ ] Often gets lost, even in a familiar city
[ ] Sometimes confuses "b" and "d", especially when tired or sick.