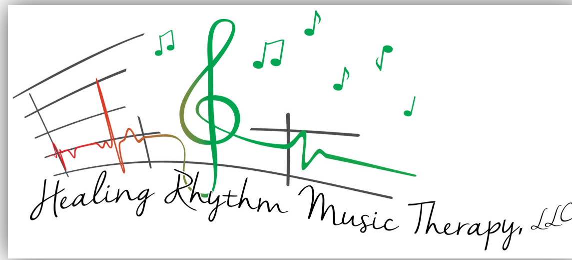


Thank you for choosing *Healing Rhythm Music Therapy, LLC* as a part of your child's development. It is our goal to provide outstanding services, support, and communication regarding your family's needs. We want you to be involved in establishing goals, treatment planning, home exercises, and discharge planning. Our intention is to move towards a level of independence within each individual's abilities.

Included in our paperwork you will find:

- Family/patient information sheet
- Financial agreement/attendance policy
- Consent to treat/medical release/permission for exchange of info
- Audiovisual release
- HIPAA policy
- IMTAP Assessment

Please read all forms thoroughly so that you are informed about the agreements you are signing, and ask any questions to better help us serve you and your family.

Additionally, some other pieces of information are requested:

- Most recent **OT/ST/PT Psychological** evaluations within the past year
- Waiver and /or grant information (if this is applicable to your child)

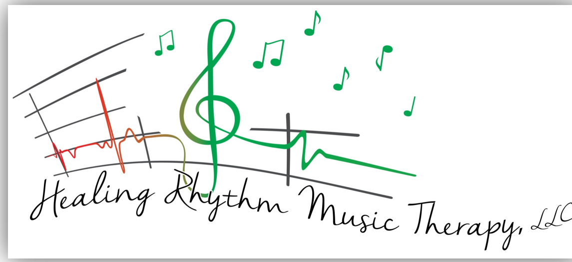
If we are billing insurance:

- Copy of driver's license
- Copy of the front and back of your insurance card
- Current prescription from PCP (Primary Care Provider)-Must state MT services 1x a week, for 12 months for specific diagnoses

Please note that these items MUST be received prior to your child's initial evaluation. If they are not received prior to your first appointment, we ask that you arrive 30 minutes early in order to complete your paperwork. We look forward to working with our family.

Thank you,

Marchele (Shelly) Gilman, MT-BC, Licensed
Owner



Patient Information Form

Patient's Name (as it appears on insurance card):_______________________________DOB:_________

Male/Female Parents' Names: ____

Address: _______________________________ City: _______________________ Zip:_________

Phone Number: ______________________ Cell Phone Number: ___________________________

E-mail: ______________________________ *Please circle preferred method of communication.

Diagnosis (if known): ____

Primary Physician: ____

Other doctors and specialists who are involved in your child's care:

Name	Specialty	Phone Number

Insurance Information (only if insurance will be billed)

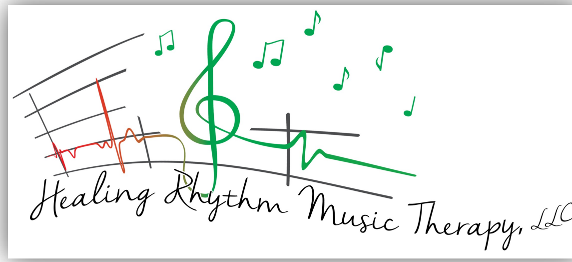
Primary Insurance: __________________________ Name of Insured: ________________________

Insured SS #: _________________________ Insured D.O.B. ____________________

Employer's Name: _______________________________ Member ID:______________________

Group #: ___________________ Claims Address (found on back of card):___________________

____



Family Background

Mother's Name:______________________ Age:__________ Occupation:_______________

Father's Name: ______________________ Age:__________ Occupation:_______________

Marital Status: ☐Single ☐Married ☐Separated ☐Widowed Is your child adopted? ☐Yes ☐No

Languages Spoken at Home (circle primary):____

Brother(s) and /or Sister(s) of the child:

Name	Age

What outcomes do you hope to see as a result of music therapy? ____________________________

____

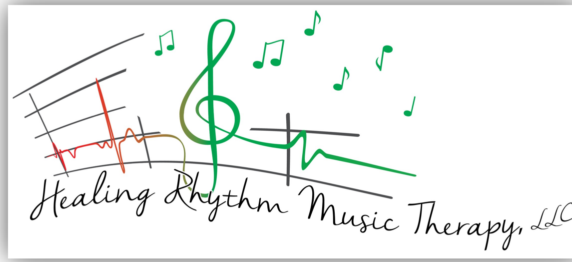
____

Does your child currently receive other therapy services? ☐ Yes ☐ No

If "Yes", **where and when**? ____

____

____



Medical History

At how many weeks was your child born? _______________ Birth weight?______________________

Were there any complications during the pregnancy or delivery? ☐Yes ☐No Please describe:_________

____

Was your child hospitalized after birth?____

Does your child have any other medical issues?____

____

Please list any hospitalizations and/or medical procedures your child has received: __________________

____

____

Current medications:

Name	Dosage	Frequency	Reason for medication

Any known allergies? ☐Yes ☐No If yes, please describe:_____________________________________

____

Any diet restrictions? ☐Yes ☐No If yes, please describe: ____________________________________

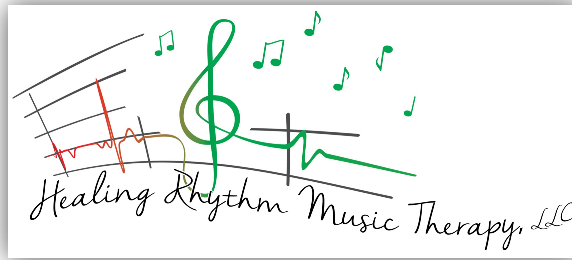
____

Is your child currently enrolled in school? ☐Yes ☐No If “Yes”, where attended:___________________

Does your child receive any services through the school? ☐Yes ☐No

If “Yes”, what services? ____

Does your child have a current Individualized Education Plan (IEP)? ☐Yes ☐No



Social/Emotional History

What are your child's favorite toys/activities?____

What are your child's favorite songs?____

What typically calms/soothes your child? ____

Is your child currently enrolled in any community activities (play groups, sports, music class, aquatic Lessons etc.)? ____

Please describe your child's strengths:____

____

Please describe behavioral concerns:____

____

Please describe health concerns:____

____

Please describe your child's sensitivities (noises, lights textures, tones of voice, etc)__________________

____

What is the typical role of music in your home?

- We listen to music in the car or home.
- We have musical instruments sitting around, available just for fun.
- Someone in our family plays an instrument and practices or takes lessons at home.
- We sing songs together sometimes/often. (Please circle)
- We often sing, clap, or dance to get through routines, tasks, etc.
- Other____

What radio stations, songs, CDs, or artists does your family usually listen to? ____________________

____

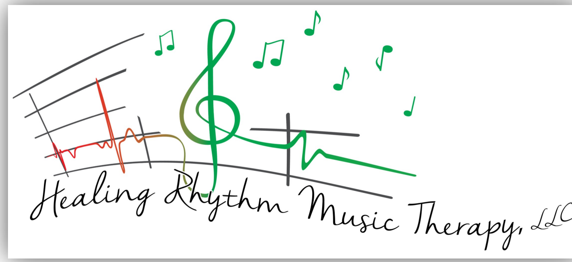
How does your child usually respond when he/she hears music being played?______________________

____

Anything else you would like to tell us about you or your family?______________________________

____

____



CHILD'S NAME:______________________________DATE OF BIRTH___________________________

FINANCIAL AND INSURANCE POLICY

If insurance is to be billed, a copy of your driver's license and insurance information is required before services begin. Benefits will be verified upon receipt of your insurance information and you will be made aware of any **estimated** out-of-pocket expenses before any services are started. Information obtained from insurance companies is **not always a guarantee of payment**. Families are ultimately responsible for payment for non-covered services. **It is imperative that families are aware of their insurance coverage and their potential responsibilities.** We will strive to keep open communication in regards to insurance and payment. Families will inform *Healing Rhythm Music Therapy, LLC*, of any changes regarding insurance. Families assign benefits for filed claims to be paid to *Healing Rhythm Music Therapy, LLC*. Any payment sent directly to the family, intended to cover therapy services provided by Healing Rhythm Music Therapy, LLC, should be given to the front office.

_______parent initials

The usual and customary rate for services is billed to insurance. If we bill your insurance and you have a deductible, **the full amount applied to your deductible will be billed to you**. Healing Rhythm Music Therapy, LLC, does not accept Medicaid, only Katie Beckett Family Directed plan. Therefore, families are responsible for all co-pays, coinsurances, and deductible expenses associated with each date of service. Please contact us directly if you are experiencing financial hardship. *Healing Rhythm Music Therapy, LLC*, accepts cash, check, VISA, and MASTERCARD.

_______parent initials

The initial evaluation for music therapy services is $65/hour. Evaluations are an out-of-pocket expense expected at the time of service. An initial evaluation will be needed for all children starting therapy with our facility. Most evaluations will last 1 hour. If a family needs a re-evaluation for insurance of person reasons, the rate will be $65/hour. Financial arrangements will be made prior to the time of evaluation.

_______parent initials

CONSENT TO TREAT

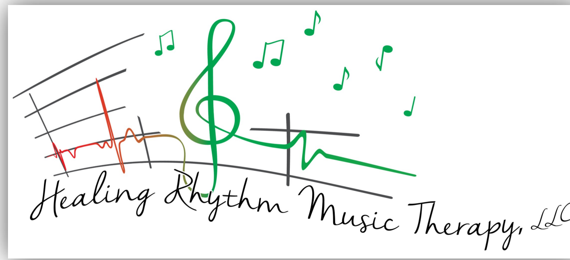
I, ____________________________consent for *Healing Rhythm Music Therapy, LLC*, to provide my child, _____________________________ with Music Therapy services. I consent to care and treatment falling under the practice guideline of the American Music Therapy Association (AMTA), and the state of Idaho or Oregon, whichever applies. I acknowledge that there is always a risk of injury with any therapy involving physical activities.

____ __________________

PARENT/GUARDIAN SIGNATURE DATE

____

PRINTED NAME



Audio/Video/Information Release

At Healing Rhythm Music Therapy, we are committed to maintaining confidentiality and honoring your privacy. We will not share any information about you or your child without your consent. In some cases, though, sharing an experience we had with your child in music therapy can help to improve the overall quality of care for future music therapy clients. Because of this, we ask you to consider the following:

I, ____ grant Healing Rhythm Music Therapy permission to share

□Video Footage
□ Audio Recordings
□ Still Image Photographs

that are taken of my child during music therapy sessions if they are used for the following purposes:

□ Educational (conference/community presentations, sharing with students, etc)
□ Research (for reference and/or publication in scholarly journals, books, etc)
□ Promotional (still images for use in Healing Rhythm Music Therapy, website, newspaper, etc)

Regarding personal information (diagnoses, presentation in music, behaviors, treatment plan(s), and other information deemed clinically relevant by the music therapist):

□ I give permission for my child's case to be discussed with the therapist's supervisor(s) and other clinicians at Healing Rhythm Music Therapy, LLC to improve the quality of his/her care.

□ I give permission for my child's case to be discussed with the other healthcare professionals who make up my child's treatment team in an effort to increase integration and cohesion among his/her various therapeutic experiences. In this case, I give permission for my child's first and last name to be used.

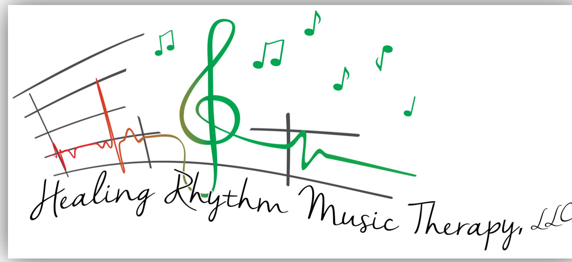
Regarding the use of my child's name in the above scenarios:

□ I give Healing Rhythm Music Therapy permission to use my child's first name.

I understand that my responses on this form will not affect my child's treatment in music therapy and that I am free to grant or withhold permission of any of these things to any extent. To indicate the cases in which I do not give my consent, I have written the word "No" next to the box. I also understand that Healing Rhythm Music Therapy, LLC will keep my child's name confidential unless otherwise indicated above.

Signature of parent/guardian:___________________________________**Date**:_______________

Healing Rhythm Music Therapy, LLC
At Crossroads Academy of Music
400 S Main
Payette, ID 83661
541-212-1716 or 208-505-8332



NOTICE OF PRIVACY PRACTICES:

Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Healing Rhythm Music Therapy, LLC. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice.

I acknowledge receipt of the *Notice of Privacy Practices* of Healing Rhythm Music Therapy, LLC.

Patient's Name: ____

Signature: _______________________________________ Date:_________________

(patient/parent/conservator/guardian)

Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

Patient's Name:____

Reasons why the acknowledgment was not obtained: ____

Patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices

Other:____

Signature of provider representative: _____________________________Date:___________