Healing Rhythms Music Therapy Intake Form

Healing Rhythms Music Therapy, LLC * 847 5th Street NW * Rochester, MN 55901 * Phone: 507-236-7793

Email: office@healingrhythmsmt.com Website: www.healingrhythmsmt.com

Patient Information Form:

Patient'sName:____

DOB:________________ Male / Female

Guardian/Caretaker Names______________________________________

Client Address: ______________________________ City:____________ Zip: _______

Phone Number:

Home ____________________________Cell_____________________

EmergencyContact: ____

E-mail: ____

Medical Diagnosis (if known):

____

____

____

____

Primary Physician: ______________________________Phone:_______________

Physician's Address: ____

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

____

____

____

Languages Spoken at Home (circle primary): ______________________________

Service Pets: ____

Necessary Accommodations:______________________________________

What are your priorities in receiving music therapy sessions from Healing Rhythms Music Therapy, LLC?____

____

____

____

Do you currently receive other therapy services? Yes/No

If "Yes", where and when/what days:___________________________________

How did you hear about us? _______________________________________

Are you approved for any Waivers? ___________________________________

If so, who is your case manager?_____________________________________

Phone:__________________Email:____________________________________

Fax:_______________________ Agency Name:_____________________________

Agency Address:____

Contact at Agency:_______________________________Phone:____________________________

Medical History:
Does Patient have any other significant medical issues we should be aware of? (ex. Seizures, allergies, etc)

____
____
____
____

IF SO Describe Plan of Action in case of episode:

____
____
____

If patient has a Behavior Intervention Plan: ___ Yes ___ No
Please attach a copy or communicate how we should handle behavioral situations:____
_

____
____

Please list any recent hospitalizations, medical procedures you have received and precautions we should take:____
____
____

Any known allergies? ⬜ Yes ⬜ No.
If **yes,** please describe:____
____
____

Any diet restrictions? ⬜ Yes ⬜ No.
If **yes,** please describe:____
____
____

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

____
____
____
____
____

PATIENT/GUARDIAN SIGNATURE ____

PRINTED NAME____

DATE ______________________**RELATIONSHIP TO PATIENT** ___________

PERMISSION FOR EXCHANGE or RELEASE OF INFORMATION: I authorize *Healing Rhythms Music Therapy, LLC* to release necessary and pertinent medical information to physicians, case managers, and insurance companies as needed for ______________________(name of patient). Approved information may be exchanged with the following people *directly* related to the patient _________________ care:

• ⬜ Doctor's ____ •
⬜ Therapist's____ •
⬜ Other: ____

Approved information includes **written documents** and/or **verbal discussion.**

PATIENT/GUARDIAN SIGNATURE _____________________**Date**_________

PRINTED NAME____

<u>Music Therapy Pricing:</u>

Initial Intake: $125 at HRMT clinic; $150 for in-home intake
Music Therapy Session: HRMT Clinic: $90/hour or $45/30 minutes
In-home Services: $120/hour; $60/30 minutes

Please note that the initial intake session may be considered an out-of-pocket expense and payment is expected at the time of service. An initial evaluation will be needed at the start of therapy with *Healing Rhythms Music Therapy, LLC*. Most evaluations will last 1 hour. If a family needs a re-evaluation for insurance or personal reasons, the rate will be $125. Financial arrangements will be made prior to the time of evaluation. ______ **initials**

CONSENT TO TREAT

I consent for *Healing Rhythms Music Therapy, LLC.* to provide Patient, (name) ___________________with Music Therapy services. I consent to care and treatment falling under the practice of Healing Rhythms Music Therapy, LLC.

Physical Movement:
I acknowledge that there is always a risk of injury with any therapy involving physical activities. I hereby release *Healing Rhythms Music Therapy, LLC* and any agents or assignees, from any and all claims for damages related to physical movement during music therapy.

PATIENT/GUARDIAN SIGNATURE ________________________________Date__________

PRINTED NAME:____

ATTENDANCE POLICY:
Because of frequent no-shows and cancellations, Healing Rhythms Music Therapy, LLC has a policy that states that we require a 24 hour notice for cancellations. **After a one-time occurrence, a $50 fee will be charged for EACH missed therapy appointment. This charge will be made to the patients account.** We understand that sickness occurs; therefore, if you think that you are sick the night before, please call us and give us notice so we may plan accordingly, and/or contact a family who is on standby for a make-up session or on a waiting list for an evaluation or services. In the event of a cancellation, we will make every effort to reschedule, as we want you to benefit from his/her therapy. If you miss 3 consecutive weeks of therapy, we will make every attempt to hold that slot, but cannot guarantee this with an extended absence. The staff at *Healing Rhythms Music Therapy, LLC* strives to meet the scheduling needs of every family. If your therapy time does not work for you, please let us know.

PATIENT/GUARDIAN SIGNATURE ______________________________Date____________

PRINTED NAME: ____

CONSENT FOR AUDIO/VISUAL RELEASE
I______________________________(Patient/Guardian) give permission for______________________________ (Name of Patient) to be audio or video taped by the therapists by or at *Healing Rhythms Music Therapy, LLC.* These audio or video taped sessions will be used for education and training purposes only (i.e., clinical supervision, conference presentations).

PATIENT/GUARDIAN SIGNATURE ________________________________Date__________

PRINTED NAME: ____

CONSENT FOR PHOTOGRAPH RELEASE

I ______________________________ (Patient or Guardian) give permission for ______________________________ (Name of Patient) to be photographed by the therapists at *Healing Rhythms Music Therapy, LLC.* These photographs can be used for education and training purposes (i.e., clinical supervision, conference presentations), and may be used by *Healing Rhythms Music Therapy, LLC* for advertisement purposes (i.e., brochures, Facebook, website, and newspapers).

PATIENT/GUARDIAN SIGNATURE ______________________________Date_____________

PRINTED NAME: ____

Electronic Communication Waiver

I____________________________________(Patient or Guardian) give permission for the therapists and staff at *Healing Rhythms Music Therapy, LLC* to communicate limited information electronically for billing and communication purposes.

PATIENT/GUARDIAN SIGNATURE ______________________________Date_____________

PRINTED NAME: ____

Updated 9/1/2021