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Creating *A Better Tomorrow* by helping children and families heal and flourish from their past into their future.

Welcome to A Better Tomorrow! Thank you for choosing A Better Tomorrow Therapy & Wellness Center, LLC! We look forward to fostering collaboration with children and families to better understand their strengths and abilities while exploring tools and resources to allow them to have a healthy and promising future.

Please complete all sections to the best of your ability. Required sections have been marked accordingly. For any questions or to request a physical copy of this form, please contact our administrative staff at (907) 222-9905.

## Submitter Details

This intake packet **must be completed by the parent or legal guardian of the patient**. If the parent or legal guardian is unable to complete the necessary forms, please notify our administrative staff as soon as possible.

Name: \_\_\_\_\_ Date of Submission: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

## Patient Details

First Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Middle Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Last Name: \_\_\_\_\_ Primary Care Provider: \_\_\_\_\_

Sex (circle one): M / F School: \_\_\_\_\_

Gender Identity: \_\_\_\_\_ School Grade: \_\_\_\_\_

## Guardian Details

Are there any custody/special arrangements that our team should be aware of? Please be aware that documentation may be requested to best allow our team to meet your needs. Y / N

### Primary Guardian

Full Name: \_\_\_\_\_

Relationship to Patient:     Adoptive Parent     Biological Parent     Foster Parent  
    Legal Guardian     Other: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip Code: \_\_\_\_\_

Email: \_\_\_\_\_ Email Appointment Reminders: YES / NO

Patient Portal Access: YES / NO    Provides access to schedule, documentation, and billing.

Primary Phone #: \_\_\_\_\_    Secondary Phone #: \_\_\_\_\_

Are we authorized to leave a detailed voicemail? *Primary #- YES / NO*    *Secondary #- YES / NO*

Text Appointment Reminders - Can ONLY be sent to primary phone #: YES / NO

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### Alternate Guardian

Full Name: \_\_\_\_\_

Relationship to Patient:     Adoptive Parent     Biological Parent     Foster Parent  
    Legal Guardian     Other: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip Code: \_\_\_\_\_

Email: \_\_\_\_\_ Email Appointment Reminders: YES / NO

Patient Portal Access: YES / NO    Provides access to schedule, documentation, and billing.

Primary Phone #: \_\_\_\_\_    Secondary Phone #: \_\_\_\_\_

Are we authorized to leave a detailed voicemail? *Primary #- YES / NO*    *Secondary #- YES / NO*

Text Appointment Reminders - Can ONLY be sent to primary phone #: YES / NO

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## Permission to Release

The individuals listed below are authorized to transport the child from A Better Tomorrow Therapy & Wellness Center, LLC premises. These individuals may be contacted in the event that we cannot get ahold of a parent/legal guardian. Legal guardians will automatically be awarded all permissions unless specific limitations are discussed.

**Authorizations** - Check all allowed permissions for the indicated individual. If you would like to make any revisions to the authorizations as stated, please speak with the front desk staff.

- Schedule Changes: Permission to add, cancel, or reschedule appointments.
- Schedule Details: Access to a schedule of appointments in verbal or written form. Schedule reminders via text or email are available upon request.
- Portal Access (Recommended only for primary caregivers): Access to schedule details, session documentation, and billing details provided through the patient portal. An email is required for portal access.
- Release of Information (ROI): Access to details of care including but not limited to written and verbal recaps of evaluation and treatment sessions, goals, and instructions.

Full Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Email: \_\_\_\_\_ Email Appointment Reminders: YES / NO

Primary Phone #: \_\_\_\_\_ Secondary Phone #: \_\_\_\_\_

Are we authorized to leave a detailed voicemail? *Primary #- YES / NO* *Secondary #- YES / NO*

Text Appointment Reminders - Can ONLY be sent to primary phone #: YES / NO

Schedule Changes  Schedule Details  Portal Access  ROI

Full Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Email: \_\_\_\_\_ Email Appointment Reminders: YES / NO

Primary Phone #: \_\_\_\_\_ Secondary Phone #: \_\_\_\_\_

Are we authorized to leave a detailed voicemail? *Primary #- YES / NO* *Secondary #- YES / NO*

Text Appointment Reminders - Can ONLY be sent to primary phone #: YES / NO

Schedule Changes  Schedule Details  Portal Access  ROI

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

## Release of Information

At A Better Tomorrow Therapy & Wellness Center, LLC your privacy and the confidentiality of your health information are of the utmost importance. To guarantee this, we at ABTAK require parental permission to release information **to anyone other than another parent / legal guardian.**

The individuals and agencies noted below are authorized to provide and receive written and verbal information pertaining to this patient's therapy and medical program. This authorization granted by this ROI will be effective for one (1) calendar year from the date of this form.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Individual/Facility: \_\_\_\_\_

Authorized Documents:     Evaluations/Plan of Care     Treatment Notes  
    Scheduling Details                     Billing Information  
    Other (please specify): \_\_\_\_\_

Individual/Facility: \_\_\_\_\_

Authorized Documents:     Evaluations/Plan of Care     Treatment Notes  
    Scheduling Details                     Billing Information  
    Other (please specify): \_\_\_\_\_

Individual/Facility: \_\_\_\_\_

Authorized Documents:     Evaluations/Plan of Care     Treatment Notes  
    Scheduling Details                     Billing Information  
    Other (please specify): \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

## Billing Details

### Primary Insurance

Insurance Company: \_\_\_\_\_ Insured ID: \_\_\_\_\_

Subscriber's First Name: \_\_\_\_\_ Subscriber's Last Name: \_\_\_\_\_

Subscriber's Relationship to Patient:  Self  Parent  Spouse  Other

Subscriber's SSN - Required if TRICARE: \_\_\_\_\_ Subscriber's Sex: M / F

Subscriber's Birthdate: \_\_\_\_\_ Subscriber's Phone: \_\_\_\_\_

Subscriber's Address: \_\_\_\_\_

Subscriber's City: \_\_\_\_\_ Subscriber's State: \_\_\_\_\_ Subscriber's Zip: \_\_\_\_\_

### Secondary Insurance (if applicable):

Insurance Company: \_\_\_\_\_ Insured ID: \_\_\_\_\_

Subscriber's First Name: \_\_\_\_\_ Subscriber's Last Name: \_\_\_\_\_

Subscriber's Relationship to Patient:  Self  Parent  Spouse  Other

Subscriber's SSN - Required if TRICARE: \_\_\_\_\_ Subscriber's Sex: M / F

Subscriber's Birthdate: \_\_\_\_\_ Subscriber's Phone: \_\_\_\_\_

Subscriber's Address: \_\_\_\_\_

Subscriber's City: \_\_\_\_\_ Subscriber's State: \_\_\_\_\_ Subscriber's Zip: \_\_\_\_\_

### Tertiary Insurance (if applicable):

Insurance Company: \_\_\_\_\_ Insured ID: \_\_\_\_\_

Subscriber's First Name: \_\_\_\_\_ Subscriber's Last Name: \_\_\_\_\_

Subscriber's Relationship to Patient:  Self  Parent  Spouse  Other

Subscriber's SSN - Required if TRICARE: \_\_\_\_\_ Subscriber's Sex: M / F

Subscriber's Birthdate: \_\_\_\_\_ Subscriber's Phone: \_\_\_\_\_

Subscriber's Address: \_\_\_\_\_

Subscriber's City: \_\_\_\_\_ Subscriber's State: \_\_\_\_\_ Subscriber's Zip: \_\_\_\_\_

## Guarantor

Please identify the **details for the person financially responsible for the patient's medical bills, hereby known as the guarantor**. This section must be completed and signed by the guarantor prior to any appointments. If this section of the form needs to be sent to another party, please notify the front desk staff.

All information is kept confidential and protected under strict privacy and security policies. This information will only be used to establish and maintain financial responsibility for services. The details requested are vital to pursuing compensation in the event that the guarantor fails to make timely payments as agreed upon.

Guarantor Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Guarantor Social Security Number: \_\_\_\_\_

## Billing Policies & Authorizations

**Initial each item and sign at the end of the section.**

\_\_\_\_\_ I authorize payment of medical benefits from my listed insurance carrier(s) directly to A Better Tomorrow Therapy & Wellness Center, LLC.

\_\_\_\_\_ I agree to notify A Better Tomorrow Therapy & Wellness Center, LLC immediately if there is a change in my insurance carrier. Failure to notify in a timely manner may result in charges being my responsibility.

\_\_\_\_\_ I understand that it is my responsibility to know and understand my insurance plan benefits as they pertain to this facility.

\_\_\_\_\_ I agree to pay my portion of the insurance deductible, co-pay, and/or co-insurance directly to A Better Tomorrow Therapy & Wellness Center, LLC within 30 days of a billed invoice.

\_\_\_\_\_ I understand that it is my responsibility to initiate discussion with the billing department if I am having trouble paying my bill.

\_\_\_\_\_ I understand failure to make timely payments will result in removal from the schedule and can result in being sent to collections for lack of payment.

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Signature

Date

## Attendance Policies & Authorizations

**Initial each item and sign at the end of the page.**

\_\_\_\_\_ I authorize A Better Tomorrow Therapy & Wellness Center, LLC to provide necessary services to my child.

### Attendance

\_\_\_\_\_ Consistent attendance is important for your child's progress. It is expected that you have greater than 80% attendance rate or have discussed attendance with your therapist. Attendance rates under 80% could result in removal from the schedule.

\_\_\_\_\_ Attendance is reviewed quarterly for both staff and clients. A report will be shared via email indicating your child's attendance history. This notification is informative, and no action is required unless stated that changes are being made to your child's schedule.

\_\_\_\_\_ I understand that consistency is in my child's best interest and agree to comply with the attendance policies as stated above.

\_\_\_\_\_ We invite you to talk to our administrative staff if you have any questions or concerns relating to attendance.

### Tardiness

\_\_\_\_\_ Timely arrival for appointments is expected. If running late, we ask that you contact the front desk with your expected arrival time. It will be at the therapist's discretion to determine if there is time to conduct a productive session with the late start.

\_\_\_\_\_ We ask that all families are back in the waiting room a minimum of 5 minutes prior to the appointment end time.

\_\_\_\_\_ More than 2 episodes of tardiness in a month could result in removal from your regularly scheduled time. Options to return to the schedule will be provided upon request.

### No Shows

\_\_\_\_\_ Notice must be given for cancellations at least an hour prior to the appointment start time. Appointments missed or cancelled with less than an hour's notice will be marked as a no show.

\_\_\_\_\_ Two or more episodes of no shows within a 90-day period could result in removal from your regularly scheduled time. Options to return to the schedule will be provided upon request.

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Signature

Date

## Emergency Medical Release

In the event that medical attention becomes necessary for your child while on A Better Tomorrow Therapy & Wellness Center, LLC (ABTAK) premises, we need your authorization to implement treatment.

Signature below indicates an understanding of this policy and grants permission for ABTAK to contact emergency personnel in the event of an emergency.

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Signature

Date

## Media Consent

We may be recording (audio, video, and digital stills) therapist & client activities associated with A Better Tomorrow Therapy & Wellness Center, LLC. These recordings may be used for educational and informational use in a variety of media. These recordings will not be shared, given, or sold for any purposes. All the recorded material is the property of A Better Tomorrow Therapy & Wellness Center, LLC.

Please read the following guidelines and select the one you agree to.

- I agree to my child participating in media for internal training purposes only.
- I agree to my child participating in media use for training purposes and marketing.
- I do not agree to child participating in media use. Do not use it for any purpose.

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Signature

Date

# HIPAA Patient Information Form

## ***For Your Protection***

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

## ***The Privacy of Your Health Records***

We understand that the information we collect about you and your health is personal. Keeping your health care information private is one of our most important responsibilities. We are committed to protecting your health care information and following all laws about its use. You have the right to discuss with the privacy officer your concerns about how your health care information is shared.

The law says:

1. We must keep your health care information from others who do not need it.
2. You may ask us not to share certain health care information. Sometimes, we may not be able to agree to your request (a court order would be an example of one of these situations).

The agreement you sign with us may cover the health care services you had before now or may have later.

## ***Who will see your protected information?***

We review your health care information and submit claims to payers you have agreements with to make sure that you get quality care and that all laws about providing and paying for your health care are being followed. We may also use your information to remind you about appointments or to tell you about treatment alternatives. We may share your health care information with health plans, insurance companies, and government programs to help you get your benefits and so that we can be paid for your health care services.

## ***Your Access to Protected Health Records***

In almost all cases, you may see your health care information. You may ask in writing to receive a copy of your health care information. If you think some of your health care information is wrong, you may ask in writing that we correct or add to it. You may ask that the corrected or new information be sent to others who have received your health care information from us.

Note: If you are younger than 18 years old and, by law, you can give consent for your own health care, then your health care information is kept private from others unless you sign an authorization form.

***Others we may share your information with***

We follow the law which tells us when we ARE REQUIRED to share health care information, even if you do not sign an authorization form. We may be required to report:

1. contagious diseases, birth defects and cancer.
2. firearm injuries and other trauma events.
3. reactions to problems with medicines or defective medical equipment.
4. to the police when required by law.
5. when the court orders us to.
6. to the government to review how our programs are working.
7. to an insurance company who needs to know if received services from us.
8. to Workers Compensation for work-related injuries.
9. birth, death, and immunization information.
10. to the federal government during the course of an investigation.
11. abuse, neglect and domestic violence, if related to child protection or vulnerable adults.

We may also share health care information for government permitted research purposes, for matters concerning organ donations and for serious threats to public health or safety.

**Notice Updates**

This notice is yours. You may ask for a copy at any time. If there are important changes to this notice, you will get a new one within 60 days if you are currently receiving services.

**Questions & Complaints**

If you have any questions regarding the notice or wish to receive additional information about our privacy practices, please contact our office. If you believe your privacy rights have been violated, you may file a complaint at our service location(s) either in person or by mail.

You may also contact the Department of Health & Social Services Privacy Official by calling 907-465-2150, or by writing to State of Alaska, DHSS Privacy Official, PO Box 110650, Juneau, AK 99811-0650, or by e-mailing the state DHSS Privacy Official at: PrivacyOfficial@health.state.ak.us. You can also contact the federal government Secretary of Health and Human Services (HHS) or to the HHS Office of Civil Rights. Your health care services will not be affected by any complaint made.

**My signature indicates that I have been provided the HIPAA policies and I understand that I am encouraged to ask questions as needed.**

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Signature

Date

## Telehealth

I understand that Telehealth is used when it is not advisable or available for me to visit A Better Tomorrow Therapy & Wellness Center, LLC in person. Reasons to use Telehealth may include but are not limited to cases of emergency, illness, quarantine, transportation issues associated with remote locations, travel restrictions, or a residential move until local services are made available.

I understand that the rules of confidentiality in Telehealth are the same as the rules of confidentiality stated in the ABTAK HIPAA Patient Information Form which I have read and signed prior.

I understand that the laws protecting the privacy of my child's medical information also apply in Telehealth. The HIPAA Patient Information form I previously read and signed also applies in Telehealth. I understand that no electronic media is perfect and on occasion, breaches of privacy may occur with Telehealth.

I understand that the information used for evaluation, therapy, follow-up and/or education, may include any of the following:

- Patient medical records
- Medical images
- Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.
- Live two-way audio and video

I understand that because A Better Tomorrow Therapy & Wellness Center, LLC. is licensed by and located in the State of Alaska, that Alaskan laws apply to the standards of care and to the handling of my child's medical records.

I understand that it is my responsibility to help make my Telehealth therapy sessions successful. I agree to the best of my ability to arrange a safe, quiet, private place with lighting and internet connection in which to participate in my Telehealth appointment. I agree to have my telephone near me (and charged if a cell phone) during my child's sessions as a backup should there be a disruption in video service due to technical difficulties.

I give my permission for A Better Tomorrow Therapy & Wellness Center, LLC to use telehealth as a means of providing for my child's therapy needs.

I have read and understand the information provided above regarding Telehealth. I hereby give my informed consent for the use of Telehealth in my child's medical care. I understand that if Telehealth proves unsuitable for my child's therapy needs, I can decline future Telehealth visits without jeopardizing my future access to direct in-office visits with ABTAK.

**My signature indicates that I have been provided with and have reviewed the telehealth policies.**

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Signature

Date

## Patient Details

What are your primary concerns/reason for seeking therapy services? Are there any specific goals you would like addressed?

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Are there any topics that you would prefer not be discussed in front of your child?

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Describe any behaviors or triggers your child has that their therapist should be aware of.

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What helps to calm your child when they are upset (activities, songs, etc.)?

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Are your child's behaviors consistent in all environments (home, school, community, etc.)?

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## Social History

We ask the following questions to better understand your child's home life. There is no judgment-our goal is to provide the most informed and supportive care possible.

What language(s) is your child exposed to at home, school, etc.?

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Are there any family dynamics our staff should be aware of? This could include who lives in the home, custody arrangements, primary caregiver, etc.

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Has your child experienced any recent life changes or stressors?

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## Medical History

Please identify any allergies your child has and the action necessary if accidentally exposed.

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Please identify any medications your child takes including when it is taken, how much, and how often.

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Has your child had surgery, been hospitalized, or experienced a known traumatic event? If yes, please explain.

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## Birth History

We ask the following questions to better understand your child's early development. There is no judgment-our goal is to provide the most informed and supportive care possible.

How far along was the pregnancy when it was discovered?

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Were there any complications during the pregnancy, labor, or delivery? If yes, please explain.

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Was the child exposed to any substances or traumas during pregnancy?

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Gestational age at birth: \_\_\_\_\_

Weight and length at birth: \_\_\_\_\_

### Developmental History

Please answer the following questions to the best of your ability - any information you're able to share helps us provide the best care for your child.

At what age did your child meet the following developmental milestones?

Sitting: \_\_\_\_\_

Crawling: \_\_\_\_\_

Walking: \_\_\_\_\_

First Word: \_\_\_\_\_

Eating Solids: \_\_\_\_\_

Potty Trained: \_\_\_\_\_

Please identify any areas in which you have concerns about your child's development.

Speech/Language

Motor Skills (fine or gross)

Social Interaction

Learning or Attention

Emotional Regulation

Other (Please Specify): \_\_\_\_\_

Please provide any additional information that you feel would be pertinent to the care of your child that was not addressed in early sections of this form.

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### Additional Documentation (if applicable)

Please identify any services or testing previously received that may be relevant to the service being received at A Better Tomorrow Therapy & Wellness Center. Include the facility/provider with which the service was rendered, approximate dates when this service was received, and identify which service or testing was completed.

We ask for a copy of this documentation to ensure the therapist can make informed decisions regarding your child's evaluation and treatment plan. These can be submitted via the patient portal, via email to BBLEAKLEY@ABETTERTOMORROWAK.COM, or provided as a physical copy during your next visit. Alternatively, you may complete an ROI and our office will request the records directly from the facility.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Facility/Provider: \_\_\_\_\_ Service Date(s): \_\_\_\_\_

- Service Type:  Neuropsychological Evaluation  Genetic Testing  
 Therapies (OT, PT, ST)  Therapies (Counseling)  
 Education Records  IEP/504  
 Other (Please Specify): \_\_\_\_\_

I  Do  Do NOT authorize A Better Tomorrow Therapy & Wellness Center to request these records directly from the indicated facility.

Facility/Provider: \_\_\_\_\_ Service Date(s): \_\_\_\_\_

- Service Type:  Neuropsychological Evaluation  Genetic Testing  
 Therapies (OT, PT, ST)  Therapies (Counseling)  
 Education Records  IEP/504  
 Other (Please Specify): \_\_\_\_\_

I  Do  Do NOT authorize A Better Tomorrow Therapy & Wellness Center to request these records directly from the indicated facility.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_