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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: _____

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.

Patient Name: _____

Patient DOB: _____

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 _____