New Client Registration

Date____________________

Name of client: ____

DOB: ____ /____ /_______ **Age:** _____________

Guardian Name: ____

Address: ____

City:______________________________ **Zip:** ______________

Phone: _____-______-__________

Email: ____

Emergency Contact:____

Phone: ______-______-__________

Allergies:______________________**Type of reaction:** _____________

Insurance/Payment Source ___________________________________

ID#________________________________

Medical History or Diagnosis __________________________________

____

Musical interests ____

____

How did you hear about Joyful Music services? ____________________

____

____

Office use only

☐QB ☐PB ☐ ☐☐ ☐ Group Class ______________________________________

☐CC ☐TXT ☐ Individual MT At home____________ At Center ______________

☐ Assigned To Therapist____

☐Assessment Date _________ ☐ Payment Plan____

☐Payment Received: Amount __________Cash ______ Check #______ Credit Card Type__________

Client Name: ________________________________ Date of Birth: _____________________

CONSENT TO TREAT

I _________________________ consent for Joyful Music Therapy, LLC to provide ___________________ with Music Therapy Services. I consent to care and treatment falling under the practice guideline of the American Music Therapy (AMTA), and the state of Florida. I acknowledge that there is always a risk of injury with any therapy involving physical activities.

Parent/Guardian Signature Printed Name Date

An initial evaluation for music therapy services is $120/hour. Evaluations are a one-time fee with payment expected at the time of service. An initial evaluation will be needed for all clients starting therapy with our facility. Financial arrangements will be made prior to the time of evaluation.

Parent/Guardian Signature Printed Name Date

CONSENT TO
ONLINE TELEHEALTH SERVICES

I _________________________ consent for Joyful Music Therapy, LLC to provide ___________________ with Online Telehealth Music Therapy Services. The purpose is to establish or maintain access to music therapy services when face-to-face contact is restricted or not available.

1) Music Therapy Telehealth Services:

a) Details of you and/or your family's medical history, music therapy assessment, music therapy treatment may be discussed through the use of interactive video, audio and telecommunications technology.

B) Video, audio, and/or digital photo may be recorded during the telehealth visit.

C) Caregivers are responsible for providing instruments for adapted lessons such as piano, guitar or ukulele. 2) **Medical Information and Records.** All existing laws regarding your access to medical information and copies of your medical records apply to telehealth visits.

3) **Confidentiality**. All existing confidentiality protections under federal and Florida law apply to information disclosed during telehealth visits.

4) **Risks and Consequences.** The use of video technology to deliver healthcare and educational services is a new technology and may not be equivalent to direct patient to professional contact.

5) **Financial Agreement.** Telehealth visits will be billed monthly at the rates listed in the policy handbook. Cancellation and No Call/No Show policies and fees apply.

Parent/Guardian Signature Printed Name Date

PRIVACY STATEMENT

CONSENT TO USE AND DISCLOSER OF HEALTHCARE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS:

We, at Joyful Music Therapy (JMT), look forward to providing Music Therapy sessions to you on a routine basis. We respect the privacy of you and your family and want you to feel comfortable regarding your private information.

- JMT maintains records describing health history, symptoms, examinations and test results, diagnoses, treatment and any future treatment plans
- Information regarding your treatment plans may be discussed among healthcare professionals who contribute to your care, upon written consent
- Demographic and billing information may be used by office staff
- Your file will be stored in a locked file cabinet

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Parent/Guardian Signature   Printed Name   Date

PERMISSION FOR EXCHANGE OF INFORMATION

I authorize Joyful Music Therapy, LLC to release necessary and pertinent medical information to physicians, case managers and insurance companies as needed. Approved information includes **written documents** and/or **verbal discussion**.

Approved information may be exchanged with the following people:

Name   Contact info

____

____

Parent/Guardian Signature   Printed Name   Date

Client Name: ________________________________ Date of Birth: _____________________

As of September 1, 2019 Payment required at time of service

Individual Music Therapy Cancellation Policy

Clients will be billed a $25 cancellation fee if a 12-hour cancellation notice is not given or in the event of a no-show.

The Board of Health considers the following signs to indicate communicable disease/illness: **vomiting, fever over 100 degrees, diarrhea, sore throat, rash/swelling, red, or running eyes**. Please be sure the client is symptom free for 24 hours before resuming therapy. Please note that if you come to therapy and he/she exhibits any of the above symptoms, it is at the therapist's discretion to send them home in order to protect themselves and our other clients from infectious illness.

Required Credit Card

Your credit card will be charged for monthly payments not paid within 60 days of invoice. If you are unable to continue participation in music therapy services, you are required to notify the instructor and/or the office by the 15th of the month, or your credit card will be billed for the remainder of the month.

I authorize Joyful Music Therapy to maintain my credit/debit card on file. I understand that my card will be used if my account has become delinquent for more than 60 days. I further agree to notify the office if there are any changes to my credit card account.

Credit Card Type ____

Card Number:____

Expiration Date:__________________ ***3 digit security code:***_____________

Name on Card: ____

Phone: ____

Cardholder Address: ____

City___________________________________***State***________***Zip***_____________________________

____ _______________________________

Cardholder Signature ***Date***

Client Name: ________________________________ **Date of Birth:** __________________________

Consent for Photograph, Audio/Video Release

I __________________________ (Parent or Legal Guardian) give permission for ________________ (Name of client) to be photographed, audio or video recorded by the therapists at Joyful Music Therapy, LLC. These photographs will be used for education and training purposes (i.e. clinical supervision, conference presentations), and may be used by Joyful Music Therapy, LLC for advertisement purposes (i.e. brochures, newspapers). At no time will the client's name be used and your identity will remain confidential. Tapes will be maintained in a locked facility.

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Parent/Guardian Signature Printed Name Date

Permission for guardian to leave site during treatment

I _____________________________ (Parent or Legal Guardian) acknowledge that I am the legal guardian of __________________________________ (client). I understand that while the client is receiving therapy I may leave the premises. However, I will give Joyful Music Therapy, LLC a working cell phone number where I can be reached during my absence. In addition, I agree that I will return prior to the end of the session. I give consent and permission to Joyful Music Therapy, LLC for any additional treatment or transportation that may be needed in the event that the client named above is injured or needs medical attention. Also, I understand that the ability to continue to leave the premises while the client is at therapy is at the discretion of Joyful Music Therapy, LLC.

I hereby release Joyful Music Therapy, LLC, and any agents or assignees, from any and all claims for damages related to my leaving the premises during the above named clients therapy.

Parent/Guardian Signature Printed Name Date

Primary Cell Phone Secondary Cell Phone Home Phone

Video Camera System

I _____________________________ (Parent or Legal Guardian) acknowledge that I am the legal guardian of __________________________________ (client). I understand that my child's likeness can be seen through the camera system in each treatment room. This is for the safety of all participants and I acknowledge that I can watch and monitor my child while they are in the care of Joyful Music Therapy. I understand that the live footage is now available via the EasyViewer Plus App to accommodate parents when they are unable to or restricted from sitting in the lobby. I understand that live footage is password protected and that each month I will receive a new password to access the system. In accordance with HIPAA compliance there is no audio recording and I will only access the system when my child is on Joyful Music Therapy premises.

To Access the Camera System:

1. Download the **EasyViewer Plus App (Apple)** from the App Store or the **EasyViewer Pro App (Android)** from the Play Store on your phone.
2. Click the Enter Button Under New Experience
3. Select the United States as your Region, the press Done at the top right corner
4. Click the plus sign at the right top corner
5. In the drop down box select SN/Scan
6. Click "OK" and allow EasyViewer Plus to use your camera
7. Scan the QR Code Provided and click the next button
8. Select DVR/XVR
9. Type in the Device Name: Joyful
10. Type in the User Name: Jview
11. Request the monthly password from the front office Staff

Parent/Guardian Signature Printed Name Date