

Children's Therapy Center

Pediatric Occupational Therapy

Helping children achieve their fullest potential.

7881 Egleberry Street, Gilroy, CA 95020 • 408-842-1121

PATIENT INFORMATION

PATIENT NAME _____ DATE OF BIRTH _____ AGE _____

ADDRESS _____ CITY, ZIP _____

PARENT NAME(S) _____ HOME PHONE _____

PARENT EMPLOYER _____ CELL PHONE _____

ADDRESS _____ CITY, ZIP _____

PARENT EMAIL ADDRESS _____

PEDIATRICIAN _____ PHONE NUMBER _____

ADDRESS _____ CITY, ZIP _____

INSURANCE COMPANY _____ PHONE NUMBER _____

ADDRESS _____ CITY, ZIP _____

SOCIAL SECURITY _____ ID#, GROUP# _____

RESPONSIBLE PARTY _____

WHOM CAN WE THANK FOR THE REFERRAL _____

Please note that insurance is considered a method of reimbursing the patient for fees paid to Children's Therapy Center, and is not a substitute for payment. It is your responsibility to pay all deductibles, copayments and any other balance not paid by your insurance company. Patients are required to pay the initial evaluation fee at the first appointment. All charges following the evaluation must be paid on a monthly basis, as determined by the Business Director/Office Manager. If this account is assigned to an attorney for collection and/or lawsuit, the prevailing party shall be entitled to reasonable attorney's fees and costs associated with the collections process. To the extent necessary to determine liability for payment and to obtain appropriate reimbursement, I authorize the disclosure of the above named patient's records.

I hereby assign all medical benefits to CHILDREN'S THERAPY CENTER, for services rendered to the above named patient. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance company; I hereby authorize CHILDREN'S THERAPY CENTER to release all information necessary to secure payment.

SIGNATURE _____ DATE _____