Children's Therapy Center

Helping children achieve their fullest potential

PATIENT & PARENT INFORMATION

PATIENT NAME_____DATE OF BIRTH_____AGE_____

ADDRESS_____CITY, ZIP_____

MOTHER'S NAME_____HOME PH#_____CELL #_____

EMAIL ADDRESS_____

MOTHER'S EMPLOYER_____WORK PHONE_____

FATHER'S NAME_____HOME PH#_____CELL#_____

EMAIL ADDRESS_____

FATHER'S EMPLOYER_____WORK PHONE_____

PEDIATRICIAN_____PHONE NUMBER_____

ADDRESS_____CITY, ZIP_____

INSURANCE COMPANY_____PHONE NUMBER_____

ADDRESS_____CITY, ZIP_____

SUBSCRIBER_____SUBSCRIBER DATE OF BIRTH_____

ID#_____GROUP #_____

RESPONSIBLE PARTY_____ADDRESS_____

NAMES & PHONE #'S OF PARTIES WHO PICK UP AND DROP OFF YOUR CHILD (GRANDPARENTS, BABYSITTERS, ETC)

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. 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 assignment 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 CNETER to release all information necessary to secure payment.

SIGNATURE_____ DATE_____