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PATIENT INFORMATION **Date:** _____

Patient Name: _____

DOB: _____ Age: _____ Sex: Male Female

Home Address: _____

_____

Reason for referral: _____

Referred by: _____

Diagnosis (if known): _____

What services are you seeking? Check all that apply.

- ❑ Speech/Language Therapy
- ❑ Occupational Therapy
- ❑ Feeding Therapy
- ❑ Applied Behavior Analysis (ABA Therapy)

CAREGIVER INFORMATION (**Please include BOTH caregivers, if applicable)

Caregiver 1 Name: _____ DOB: _____

Relationship to patient: _____

Phone: _____ Home/Cell/Work

Email: _____

Occupation: _____

Employer: _____

Employer Address: _____

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Caregiver 2 Name: _____ DOB: _____

Relationship to patient: _____

Phone: _____ Home/Cell/Work

Email _____

Occupation: _____

Employer: _____

Employer Address: _____

Parents/Caregivers are: Single Married Divorced Separated

Child lives with: Parent 1 Parent 2 Both Parents Other: _____

EMERGENCY CONTACT

Name: _____

Relationship to patient: _____

Phone: _____ Home/Cell/Work

Email _____

MEDICAL INFORMATION

Primary Care Physician: _____

Clinic/Group Name: _____

Clinic Address: _____

Phone: _____ Fax: _____

Email: _____

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FINANCIAL INFORMATION

Person responsible for account: _____

Relationship to patient: _____

Phone: _____ Email: _____

In-Network Insurance: AETNA BCBS/Anthem CIGNA-OT/ABA/some ST

Katie Beckett Medicaid SSI Medicaid TriCare ST/OT

Out of Network Insurance: United Humana CIGNA-ST Other: _____

Subscriber Name: _____

Subscriber DOB: _____ Subscriber Sex: Male Female

Policy #: _____ Group #: _____

Employer/Group Name: _____

Provider Services/Customer Services Phone Number (on card): _____

Does patient have Katie Beckett waiver? Yes No #: _____

Does patient have SSI Medicaid? Yes No #: _____

My signature indicates that, to the best of my knowledge, all information provided above is accurate and current. I understand that if my insurance or Medicaid information changes at any time, it is my responsibility to notify A to Z Pediatric Therapy, LLC of the noted changes. Failure to do so will result in my responsibility for payment of services if insurance/Medicaid denies services due to lack of authorization and/or verification of benefits. Please note: verification of benefits does not ensure payment of services. I authorize my insurance and Medicaid benefits be paid directly to A to Z Pediatric Therapy. I understand that I am financially responsible for any balance. I also authorize A to Z Pediatric Therapy to release any information needed to process my claims. Lastly, I understand that my child and his/her parents or guardians are at all times considered the 'client' and therefore, the direct recipient of therapeutic services regardless of any third-party involvement in the funding of these services.

Name: _____

Signature: _____

Date: _____