Pediatric Therapy Associates
PATIENT INFORMATION

ICD 9 Code:

Patient's Name | Patient's Date of Birth | Social Security Number | **M / F**

Street Address (or Preferred Mailing Address) | City/Zip Code | Preferred Phone Number

Name of School if Patient is a Student

Is Patient Receiving Therapy at School? **YES NO**
Have Prescription for Therapy? **YES NO**

Referring For: **O.T. P.T. S.T.**

Diagnosis

Name of Primary Care Physician | Office Location | Name of Referring Physician (if other than primary care physician)

PARENT/GUARDIAN INFORMATION

Father's (Guardian's) Name | Work Phone | Cell Phone

Mother's (Guardian's) Name | Work Phone | Cell Phone

Street Address (or Preferred Mailing Address for Parent/Guardian Correspondence) | City/Zip Code | Home Phone Number

Email Address for Parent/Guardian Correspondence

Name of Emergency Contact Person (relationship to patient) | Daytime Phone | Cell Phone

INSURANCE INFORMATION (Primary & Secondary)

Primary Insurance Name (If Texas Star Medicaid, please also list name of Medicaid provider … AmeriGroup, Driscoll Children's Health Plan or Superior Health)

Name of Insured | Social Security Number

Policy or Case Number | Group Number

Policy Effective Date | Employer Name

Secondary Insurance Name (If Texas Star Medicaid, please also list name of Medicaid provider … AmeriGroup, Driscoll Children's Health Plan or Superior Health)

Name of Insured | Social Security Number

Policy or Case Number | Group Number

Policy Effective Date | Employer Name

I understand that I am financially responsible for all services rendered after payment of insurance benefits.
I authorize payment of medical benefits to the undersigned therapist or supplier of services rendered.
I authorize the release of any medical or other information necessary to process claims.
I authorize Pediatric Therapy Associates to provide Occupational Therapy (OT) / Physical Therapy (PT) / Speech Therapy (ST) to my child.
I acknowledge verification of insurance benefit is done as a courtesy and not a guarantee of payment, coverage, or benefits stated by your carrier.

Signature | Date