PATIENT INTAKE FORM Date: _____

Patient Information

Child's Full Name: _____ Age: _____

Date of Birth: _____/_____/_____ Gender: _____

Child's Home Address: _____

City/State/Zip: _____

What is the primary concerns for having your child evaluated and treated?

_____

_____

Medical Information

Referring Physician _____Primary Physician _____

Clinic Name: _____ Phone: _____

Parents/Legal Guardian Information

Guardian Name (1):_____Date of Birth: _____

Street Address: _____City/State/Zip: _____

Email: _____ Occupation: _____

Cell Phone: _____ Work Phone: _____Home Phone: _____

Preferred Method of Contact (please circle): Cell Text Email Work Home

Guardian Name (2):_____Date of Birth: _____

Street Address: _____City/State/Zip: _____

Email: _____ Occupation: _____

Cell Phone: _____ Work Phone: _____Home Phone: _____

Preferred Method of Contact (please circle): Cell Text Email Work Home

Emergency Information

Emergency Contact: _____ Phone: _____

Relationship to child: _____

Insurance/Payor Information & Financial Responsibility

Individual financially responsible for patient (amounts not covered by insurance): _____

Primary Insurance Plan Name: _____

Policy Holder's Name: _____ Relationship to patient: _____

Member ID/Policy #_____Group #: _____

Insured SS #: _____ Insured Date of Birth: _____

Secondary Insurance Plan Name: _____

Policy Holder's Name: _____ Relationship to patient: _____

Member ID/Policy #_____ Group #: _____

Insured SS #: _____ Insured Date of Birth: _____

Insurance Authorization and Assignment of Benefits

I hereby authorize payment by my insurance carrier of the benefits, otherwise payable to me, to be made directly to Treehouse Therapies, LLC for their services.
I certify that the information given by me in applying for payment is correct. I request that payment of the authorized benefits be made on behalf. I assign benefits payable for services to Treehouse Therapies, LLC.
I authorize Treehouse Therapies, LLC to release all and any information to my insurance companies and/or compensation carriers, such as diagnostic, therapeutic, and financial information as may be necessary to determine benefits entitled and to process payment claims for health services that will be provided.

I understand and agree that I am financially responsible for all co-pays, coinsurance and amounts not covered by my healthcare provider. I understand these charges/payments are due at time of services.

Responsibility Party: _____
Date: _____

CONSENT TO TREATMENT/CONSENT TO RELEASE INFORMATION

Patient Name: _____

I authorize the staff at Treehouse Therapies, LLC including physical, occupational, and speech therapists as well any support staff to provide care which they deem beneficial to myself or my child. I consent to the rendering of therapeutic treatment for the above named child as considered being necessary and appropriate by the physical, occupational, and speech therapists at Treehouse Therapies, LLC. **The consent to receive therapeutic treatment/services includes, but is not limited to, therapy involving: exercise equipment, gym equipment, food and cooking activities and other services which may be used in treatment of Patient.**
Furthermore, I understand that Treehouse Therapies, LLC has promised no specific outcomes or guarantees as to the services provided at this facility.

If I have any questions or concerns regarding therapy Treatments, I will ask my attending therapist to provide me with additional information. I also understand that my attending therapists may ask me to sign additional informed consent documents concerning therapeutic treatments.

X_____ X_____
Signature Patient Name

_____ _____
Relationship Date

I authorize the physical, occupational, and speech therapists and support staff of this facility consent to release any or all pertinent medical information to the referring physician and any additional physicians to maintain quality of care. Furthermore, I authorize Treehouse Therapies, LLC to release information to insurance providers to coordinate payment of benefits.

X_____ X_____
Signature Patient Name

_____ _____
Relationship Date