'more than words' **PEDIATRIC THERAPY ASSOCIATES, INC.**

Speech, Physical & Occupational Therapy

PATIENT INFORMATION FORM

Name:_____ **Nickname:**_____

Please Check One: Male___ Female____ **DOB:**_____ **Patient SS #**_____-____- _____

Address_____**City**_____**State**____**Zip**_____

Home Phone#:_____ **Cell #**_____**Other Ph #**_____

Mother's Name :_____**Father's Name:**_____

Primary Insurance Name:_____**Policy#:**_____

Group #:_____**Policy Holder's Name**_____ **DOB**_____

SS#_____-____-_____ **Address** ***(if*** *different from patient)*_____

Employer Name:_____ **Phone:**_____

Secondary Insurance Name:_____**Policy#:**_____

Pediatrician's Name:_____ **Phone #** _____

Emergency Contact Name_____ **Phone #:**_____

Address _____**Relationship to Patient**_____

INSURANCE AUTHORIZATION/ RESPONSIBILITY

I authorize 'more than words' Pediatric Therapy Associate, Inc. to bill my insurance on my child's behalf for services rendered to my child payable to the same. I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I also understand that should I not pay in full for any services that may be subject to collection fees, should my account be turned over. I have read all the information and have completed the above answers. I certify the information is true and correct to the best of my knowledge. I will notify you of any changers in my child's therapy or the above information. By signing below I am authorizing 'more than words' Pediatric Therapy to initiate and treat my child for all doctor approved services they may qualify for.

Signature of Parent/Guardian:_____ Date:_____