Developmental Pediatric Therapy Clinic

385 CenterPointe Circle, Suite 1325 Altamonte Springs, FL 32701

Patient Name: _____ Date of Birth: _____

Address: _____ Home Phone:_____

City: _____ Zip: _____ Cell Phone:_____

Parent Information:

Mother's Name: _____ Work Phone: _____

Employer:_____

Father's Name:_____ Work Phone: _____

Employer:_____

Insurance Information:

Insured's Name: _____ Date of Birth: _____

Insurance Company Name:_____ HMO?_____ PPO?_____

Insurance ID No:_____ Group No: _____

Billing Address:_____

Do you have a secondary insurance company? _____Yes _____No

Other Funding Sources:

_____Medicaid: ID No: _____ HMO Name: _____

_____Medicaid Waiver: Support Coordinator Name: _____ Phone: _____

_____Other: Explain: _____

Please Read and Initial each section below:

_____**All Patients**: I understand that I am responsible for payment of fees for professional services rendered, regardless of my insurance company's determination of payable benefits. Unless the Developmental Pediatric Therapy Clinic is a directly contracted provider with my insurance company, I understand that it is my responsibility to handle problems which may arise with my insurance company, and that the Clinic is simply filing my insurance claim as a courtesy to me. I also understand that my appointments represent time that is specifically set aside for me or my child and that this time is not overbooked to compensate for my possible absence or tardiness. Therefore, I should give the Clinic advance notice of any cancellation as soon as possible. Continued "no shows" without calls, or late in the day calls without sudden illness will result in charges that I will be responsible for and that will not be covered by insurance or a third party payer.

_____**Medicaid Patients**: I understand that it is my responsibility to notify this Clinic if I or my child becomes ineligible for Medicaid services or if my account falls under a Managed Care Program, or if I change programs. I will be responsible for any charges incurred if I become ineligible without notifying this Clinic.

_____**Consent for Treatment**: I hereby give consent for the Developmental Pediatric Therapy Clinic to provide therapy services for the above named patient.

_____**Authorizations**: I hereby give authorization for this clinic to release records to my insurance company or third party payer, and for my insurance company or third party payer to pay benefits to the Developmental Pediatric Therapy Clinic.

_____**Privacy Practices**: I acknowledge that I have reviewed the Notice of Privacy Practices, which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used and that the organization is not required to agree to the restrictions I request. I also acknowledge the limitations of privacy that the gym setting creates, and will request a private room at any time I wish to discuss sensitive health information.

Patient or Guardian Signature: _____ Date: _____