Children's Therapy Group, Inc.

Providing Pediatric Speech, Occupational, and Physical Therapy
65 Darcee Court
Lawrenceville, GA 30046
Phone: (678) 858-4777 Fax: (678) 985-3953
childrenstg@yahoo.com

Client Information

Name:_____ DOB:_____ AGE:_____
Gender:_____

Parent(s)/Guardian(s):_____ Home Phone:
_____
Cell Phone (Mother):_____ Work Phone
(Mother):_____
Cell Phone (Father):_____ Work Phone
(Father):_____
Email address:_____

Home
Address:_____
_____
__

Physician:_____ Phone
Number:_____
Group/Facility Name:_____ Fax
Number:_____

Does your child have a medical diagnosis? ___ Yes ____ No If yes, explain
_____
_____
__
_____
_____
____

Is your child under the care of any other physicians, therapists, or specialists? ____ Yes ____ No If yes, explain
_____
_____
_____
_____
_____

Are there any medical precautions that need to be taken during treatment of your child? ____ Yes ____ No If yes, explain
_____
_____

_____
____

Has your child received previous therapy (Speech, OT, PT)? ___ Yes ___ No If so, how long?
_____
_____
__

What are your concerns regarding your child's development?
_____
_____
_____
_____
_____
_____

What would you like to see your child be able to do as a result of receiving therapy (Speech, OT, PT)?
_____
_____
_____
____

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Authorization Form

Treatment:

I, _____, hereby authorize **Children's Therapy Group, Inc.** to evaluate and/or provide speech-language/occupational/physical therapy services for
_____.

Release of Information:
I authorize **Children's Therapy Group, Inc.** to release pertinent protected health information (PHI), for the above client, in order to provide treatment, process payments and perform necessary healthcare operations.

Billing:
I authorize **Children's Therapy Group, Inc.** to bill any participating parties for speech language pathology/occupational/ physical therapy services received by the client. These parties include the following:
(Please check all that apply and fill in information for each below)
____ Insurance ____ Medicaid ____ Babies Can't Wait
____ PeachCare for Kids (Wellcare, Amerigroup, Peach State)

Insurance Information

Primary Insurance Company
_____

Address/Phone Number for claims

_____

Name of Primary Cardholder _____ Date of Birth

_____

ID # _____ Group #

_____

Name of Employer

_____

Secondary Insurance Company

_____

Address/Phone Number for claims

_____

Name of Primary Cardholder _____ Date of Birth

_____

ID # _____ Group #

_____

Name of Employer

_____

Medicaid / PeachCare for Kids Information

Medicaid #

_____

Full Name of Client

_____

Name of Primary Care Physician

_____

Babies Can't Wait Information

Babies Can't Wait Service Coordinator

_____

Cost Participation _____

_____

_____

Signature of Parent / Guardian **Date**