New Patient Application Form

Today's Date: _____

Patient Information:

Child's Name: _____

Child's Date of Birth: _____ **Age:** _____ **Child's Gender:** ☐ **Male** ☐ **Female**

Home Address: _____

Patient's Diagnosis (*prescribed by physician):* _____

Therapy Services Interested in: ☐ **Occupational Therapy** ☐ **Speech Therapy** ☐ **Both**

School: _____ **Grade:** _____

Referred By: _____

Parent/Legal Guardian(s) Information:

Parent/Legal Guardian: _____

Date of Birth: _____ **Email Address:** _____

Employer: _____ **Job Title:** _____

Mobile Phone: _____ **Work Phone:** _____

May we disclose the child's treatment information to this person? YES___ NO____
May this person receive the coverage and benefits information? YES___ NO____
May we e-mail this person regarding the cover and benefits information after verification? YES___ NO____

Parent/Legal Guardian: _____

Date of birth: _____ **Email Address:** _____

Employer: _____ **Job Title:** _____

Mobile Phone: _____ **Work Phone:** _____

May we disclose the child's treatment information to this person? YES___ NO____
May this person receive the coverage and benefits information? YES___ NO____
May we e-mail this person regarding the cover and benefits information after verification? YES___ NO___

Emergency Contact Information: (*must be different than parent(s) listed above)*

Name: _____ **Relationship to Child:** _____

Phone Number: _____

Insurance Information: (*omit if private pay)*

Insurance Company: _____ **Insurance Phone #: (*provider line*)** _____

Policyholder's Name: _____

Policy Number: _____ **Group Number:** _____

Primary Care Physician/Pediatrician & Vaccination Policy

Name: _____ **Phone Number:** _____

Address: _____ **Fax Number:** _____

Vaccinations are up to date: ☐ **Yes** ☐ **No**

This is a statement of our vaccination policy. We firmly believe, based on all available literature, evidence, and current studies, that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and Prevention and the American Academy of Pediatrics. Because we are committed to protecting the health of all patients as well as our staff and their families, we require all patients to have up to date vaccinations.

Parent/Guardian Signature: _____

Acknowledgement:

This is a statement of our financial policy. You understand that you are obligated to ensure that our fees are paid in full. We will verify your coverage and bill your insurance carrier on your behalf when using insurance. However, you are ultimately responsible for payment of your bill.

Foundations Pediatric Therapy of Houston, PLLC has made me aware of funding options available for my child.

As the guardian of:

Child's Name: _____

I choose to receive therapy services through Foundations Pediatric Therapy of Houston, PLLC and will be responsible for any charges up-front, as services are rendered. I have been aware that Foundations Pediatric Therapy of Houston, PLLC will file my third-party payer as **an out-of-network provider** and I may or may not be reimbursed any amount, dependent on my coverage.

Parent/Guardian Signature: _____

Parent/Guardian Printed Name: _____