The Therapy Center
OF HENDERSONVILLE

Physical Therapy | Occupational Therapy | Speech Therapy

ADULT NEW PATIENT INFORMATION/AUTHORIZATION TO TREAT

Patient Information

Patient Name: _____ Email: _____

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

Home Address: _____

Address City Zip

Mailing Address: _____

(If different from Home) Address City Zip

☐Home Phone: _____ ☐Cell Phone: _____

(Check Preferred Contact Phone) May we leave a message at your preferred phone number? ☐Yes ☐No

_____ (Caregiver initials) I consent to receive text messages and/or emails from this practice for future appointment reminders and for communication with therapists/office staff as needed in order to provide the best quality care for my child.

Person to contact in case of emergency: _____

Relationship: _____ Phone #: _____

**If patient is a minor, please provide us with the following information:

Parent/Guardian Name: _____ Home Phone: _____☐May we contact you at this number?

Parent/Guardian Employer: _____ Work Phone: _____☐May we contact you at this number?

Insurance Information

Primary Insurance: _____ *Please present card at time of visit.

Group Number: _____ Member ID#: _____

Name of Insured: _____ Date of Birth of Insured: _____

Secondary Insurance: _____ *Please present card at time of visit.

Group Number: _____ Member ID#: _____

Name of Insured for secondary insurance: _____ Date of Birth: _____

Referral Information

Primary Physician: _____ Phone: _____

Referring Physician: _____Phone: _____

Diagnosis: _____

Informed Consent

I, _____, do hereby agree and give consent for The Therapy Center to furnish medical care and treatment. These services are considered consistent to records as necessary for medical review by insurance providers, referring physicians, attorneys or medical case managers. I consent to the release of my child's medical records as necessary for medical review by insurance providers, referring physicians, attorneys, medical case managers, or TEIS coordinators. I give consent for the therapists to talk with school personnel when needed in order to provide the best continuity of care. All patient information is confidential. I understand that I may refuse treatment for my child at any time for any reason. I agree to hold The Therapy Center or its clinical staff harmless from any claims in excess of professional liability limits. I authorize submission of reimbursement claims to my health insurance providers or TEIS. I agree to pay copays and any outstanding balances not covered by insurance for therapy services. If the balance is not paid within a timely manner, I agree to pay any and all collection fees associated with bad debt on my account for services rendered. I understand that all consent is valid form the initial visit to The Therapy Center.

____ I hereby authorize The Therapy Center to provide treatment as prescribed by my physician for my child.

____ I hereby assign all insurance benefits for services rendered to be paid directly to The Therapy Center.

____ I understand that if my insurance co/third party payer denies payment or makes partial payment, I am responsible for the balance due.

____ I hereby authorize the release of my child's medical records to The Therapy Center for therapy and any pertinent information concerning the patient for the provision of care and for obtaining insurance reimbursement.

____ I understand that I am legally responsible for payment of all services rendered by The Therapy Center. Insurance is being billed as a courtesy.

____ I am responsible for paying any deductible or co-insurance amounts.

____ I understand that co-payments are due at the time of service.

_____ _____

Signature of Patient/Parent or Guardian/Legal Conservator Date