Telephone: 470.323.6711 Fax: 478.575.2359 Email: kidzspeaktherapy@gmail.com

Patient Intake and Financial Form

Patient Name: _____ Date: _____

Date of Birth: _____ Gender: (M) _____ (F) _____

Home Address: _____

_____

Home Phone: _____Cell Phone: _____

E-mail address:

_____

Mother's Name: _____DOB: _____

Father's Name: _____ DOB: _____

Pediatrician/Doctor:

_____

Clinic Name:

_____

Phone: _____ Fax: _____

Child's Diagnosis (if known) and Year:

_____

Reason for Referral (Concerns):

_____

Thank you for choosing Kidz Speak Therapeutic Services, LLC. We want to provide the best possible services to all of our patients. We will do our best to schedule appointments that meet your needs. **Regular attendance is important to your/your child's success. We ask that you follow the attendance policies outlined below:**

1. **Cancellations:** Please call us at least 12 hours in advance to cancel your appointment. We reserve the right to charge a $30 fee if you do not give us 12 hours notice. Insurance will not cover this fee. Failure to comply with the 12 hour advanced notice will result in the session being counted as a missed appointment. Sudden illness and emergency related situations are taken into consideration.

2. **Missed Appointments: If you cancel or miss 3 sessions within a 2 month time period, we will put your services on hold until scheduling problems can be worked out or services may be discontinued.**

3. **Late for Appointments:** If you are more than 15 minutes late for your appointment, we reserve the right to cancel the appointment and consider it a missed appointment (see policy for missed appointments above). *If you are late for 3 or more sessions, we reserve the right to put your services on hold until scheduling problems can be worked out.*

4. **Clinician Cancellations:** If your therapist is not able to attend your appointment, you will be contacted as soon as possible. Please be sure that our office knows the best way to reach you. *Every effort will be made to reschedule your appointment in a timely manner.*

To cancel an appointment call 470.323.6711 or e-mail kidzspeaktherapy@gmail.com

___ I agree to the attendance policies outlined above.

_____ _____

Print Patient's Name Date

_____ _____

Parent/Guardian Signature Relationship to Patient

KIDZ SPEAK
Therapeutic Services

Treatment Authorization

I agree to allow Kidz Speak Therapeutic Services LLC to provide Speech-language pathology, Occupational and/or Physical Therapy services for myself or my child. In addition:

I have seen and agree with the treatment goals and therapy plan.

I agree to attend scheduled therapy sessions (see attendance policy).

I agree to participate in my child's/loved one's treatment, as appropriate.

I understand that my child/loved one may be given work to do at home. I agree to help my child/loved one do this work to help with treatment goals.

_____	_____
Print Patient's Name	Date
_____	_____
Patient or Parent/Guardian Signature	Relationship to Patient

Therapeutic Services

INSURANCE INFORMATION

Primary Insurance: _____ Phone: _____

Subscriber's Name: _____Subscriber's DOB:_____

Policy ID #: _____Group #:_____

Employer/Group Name:_____

Katy Beckitt Waiver: □ Yes □ No

Medicaid: □ Yes □ No

Medicaid #: _____

My signature indicates that, to the best of my knowledge, all information provided above is accurate and current. I understand if additional service time is requested on my part above what is recommended, I agree to pay the current private pay rate for any additional service time. I understand that if my insurance or Medicaid information changes at any time, it is my responsibility to notify Kids Speak Therapeutic Services, LLC of the noted changes. Failure to do so will result in my responsibility for payment of services if insurance/Medicaid denies services due to lack of authorization and/or verification of benefits.

Signature:_____Date:_____

_____

Name of Person Completing This Form

_____

Relationship to Patient