PATIENT AND FAMILY INFORMATION

Patient Name: ______________________________________ Birth Date: _____________________
Current Address: ____________________________________ Phone: _______________________
City________________ State___________ Zip ___________ Cell Phone: ____________________
E-mail Address_______________________________________ Patient SSN ___________________
Copy Parent ID
Parents Names: _____________________________________ Diagnosis: _____________________
Referring Doctor: ___________________________________
Nickname: ____
Guardian Name if not Parents: ____
Relation of Guardian to Patient: ____
Emergency Contact Person: ______________________________ Phone ___________________________
Relation of Emergency Contact Person to Patient: ____
If Parents are not Guardians, are they to be notified in an emergency? ______________________________
Patient's Siblings and Ages: _________________________ ______________________________
_________________________ ______________________________

REASON FOR VISIT

____
____
____

Does Patient have an affiliation with Family Outreach, AWARE, Hearts & Homes, or some other case management group: ____
Does Patient go to a Day Care Center: ____
Does Patient attend School: ____ Grade: ____________
If so, is there an IEP: ___________________________
Does Patient participate with Eagle Mount: ____
Has Patient been evaluated by Montana Adaptive Equipment Program: _______________________________
Has Patient attended any specialty clinics such as infant Evaluation at Bozeman Deaconess, Child Find, or others: ____
Do we have permission to get copies of all pertinent labs, MRIs, swallow studies, genetic tests, IEPs, immunization records, and doctor's notes relating to referral for services? **If so please complete a release of medical records form.**

INSURANCE INFORMATION

Primary Insurance Company: ____
Subscriber Name: ________________________________ Birth Date:_________________________
Subscriber SSN: _________________________________ Policy ID: __________________________
Group number or Name: ____
Address of Subscriber if not same as Patient: ____

Secondary Insurance Company: ____
Subscriber Name: ________________________________ Birth Date: _________________________
Subscriber SSN: _________________________________ Policy ID: __________________________
Group number or Name: ____
Address of Subscriber if not same as Patient: ____

Other Insurance Company: ____
Subscriber Name: ________________________________ Birth Date: _________________________

Subscriber SSN: ___________________________________ Policy ID: _______________________________
Group number or Name: _____________Address of Subscriber if not same as Patient: ___________________
If Patient is covered by Medicaid, who is the Passport Provider: ________________________________

Please sign here to give this office permission to bill your insurance company and share information with them concerning your child's care._______________________________

We will bill all insurance claims and you will not get a bill until those claims are processed. If you are meeting a deductible for services or services are not covered, a payment plan will be worked out that fits your family's needs. Compliance with therapy is important for your child to make progress. We try very hard to make therapy affordable for all patients.

APPOINTMENT AND CANCELLATION POLICY

We attempt to be very prompt with appointment times and not keep patients waiting. We appreciate your help with keeping appointments and letting us know when you will not be in. Missed appointments reduce therapy effectiveness and can lead to an additional charge if they become a problem. A history of missed appointments may lead to your child losing a place in the schedule.

HIPAA COMPLIANCE

This office is HIPAA compliant and values your privacy. Please read our Privacy Policy and **sign here** that you have done so.____

RELEASE OF INFORMATION FORM

I, __________________________________, the parent/guardian of _____________________, give permission to Epicenter Therapy Services PLLC and Christa Drab, MS CCC-SLP to share information about my child's treatment with the following physicians (Please initial below) for date of service to include ____________________ to _________________.

___________________________________ ______________________

Signed **Date**

DOCTOR CONTACT INFORMATION

Primary Care Provider: ____
City: ________________________________ **Phone:** ______________________________
Do you have a Prescription or Referral: ____

Pediatrician: ____
City: ________________________________ **Phone:** ______________________________
Do you have a Prescription or Referral: ____

Neurologist____
City: ________________________________ **Phone:** ______________________________
Do you have a Prescription or Referral: ____

Orthopedist: ____
City: ________________________________ **Phone:** ______________________________
Do you have a Prescription or Referral: ____

Other: ____
City: ________________________________ **Phone:** ______________________________
Do you have a Prescription or Referral: ____