Therapy Services

Date:_____

Child's Name: _____ DOB:_____

Child's Address:_____

City_____ Zip code_____

Child's Diagnosis:_____

Parent's Name: _____Email: _____

Phone Number:_____

Therapist Name: _____ Date of 1st visit:_____E/TX

Name of Child's Primary Care Physician: _____

Physician's Phone Number:_____

Name of Insurance:_____ Eff Date: _____

Address of Insurance Company (for claims):_____

_____

Phone number of Insurance Company:_____

Group ID Number (or Group Name):_____

Policyholder's ID / Policy Number:_____

Name of Policy Holder:_____

Policyholder's Date of Birth:_____

Policyholder's Social Security Number:_____

Policyholder's Address: (N/A if Same as child) _____

Policyholder's Employer:_____

I authorize the release of any information necessary to file a claim to my insurance company. I authorize payment of benefits to Therapy Services. I agree to pay for any collections or legal fees associated with obtaining payment for services rendered and to pay for all services rendered and remainder balances due.

_____ _____

Signature of person Completing Form Date

THERAPY
P.O. Box

Fax

Medical Release

I _____ hereby certify that I am a parent or legal guardian of _____ and give Therapy Services permission to provide services to _____. I authorize Sunrise to request, obtain and provide medical information to and from the appropriate doctors, medical facilities, insurance companies and/or payment sources. I also authorize payment of benefits to Therapy Services for services provided.

By signing this release, Therapy Services has permission to discuss and share written records/notes/reports with each other for issues relating to development and programming for my child.

_____ _____

Signature of Parent or Guardian Date

THERAPY
480-
Fax 480-

Therapy Attendance Policy

Due to the large and growing number of patients waiting for therapy services and the limited number of available therapists, we find it necessary to establish an attendance policy to ensure commitment to our therapists and their valuable time. Furthermore, the consistency of therapy is critical for client-therapist rapport as well as for improvements in skills.

It is necessary that you commit yourself to your/your child's scheduled appointments wholeheartedly. A 24-hour cancellation is kindly requested, so that the therapist may make changes to her schedule if possible. We appreciate your commitment to this matter and should 3 cancellations or no-shows occur without a makeup in the same week, we would consider it just cause for termination of therapy services.

A 30.00 fee will be charged for any session missed with less than 24-hour notice without makeup in the same week missed.

Your signature below indicates you have read and understand this form.

_____ _____

Client/Guardian Witness

_____

Date

I acknowledge that I have received the Notice of Privacy Practices information through _____ Therapy Services.

_____

Child

_____ _____

Parent/Caregiver Relationship to Child

_____

Date