Children's Therapy Services, PLLC
1601 Bell Springs Rd, Dripping Springs TX 78620
(512) 331-1999 www.homeCTS.com

Patient Intake Form

Today's date: ____________

Legal guardian's name (*providing this info if other than Patient*): ____
Guardian's relationship to patient: ________________________________

Patient's full name: _________________________________ ☐male ☐female Date of birth: ____________
Street address: ____
City: ______________________________________ State: _________ Zip: ________________________
Best phone: _________________________________ Best email : _________________________________
______*(initial)* I consent to a detailed message regarding insurance coverage or questions be left at the above listed phone number.
______*(initial)* I consent to be contacted at the above listed email with insurance coverage information and/or billing details.

Patient's primary physician: ___________________________________ Physician phone: __________________
Patient's medical diagnosis: ____

Insurance Company: _____________________________ Claims/Customer Service Phone: __________________
Insurance ID number: _______________________________ Group/Plan number: ________________________
Primary Insured Full Name: ____ and Date of birth: ____________
Employer: ______________________________________ Relationship to Patient: _________________________

Consent and Conditions for Treatment

I, _____________________________, Parent/Legal Guardian of _______________________ (Patient's Name) consent and grant permission to Children's Therapy Services PLLC including the employees, therapists, contractors hereby known as "CTS" to render physical therapy, occupational therapy, speech-language therapy care including assessments, evaluations, treatment procedures beginning on ______________ . I acknowledge that no guarantee or warranty has been made by the physician or CTS as to the results of any services or treatments which may be given.

______ *(initial)* CTS is hereby authorized to furnish and release medical information to my private insurance carrier, or third party payer as maybe required for the determination of benefits payable for therapy services rendered. In consideration of services rendered or to be rendered, I hereby assign and transfer to the billing therapist, any benefits payable under any health care coverage for the payment of such benefits directly to the providing therapist.

______ *(initial)* I have been provided with the oppurtunity to review CTS Notice of Privacy Practices. I adknowledge I have read and authorized the uses and disclosure information as described. I understand that CTS has the right to change these practices and a revised copy will be posted on the website or I can request a revised copy.

______ *(initial)* I understand that my insurance company is billed on my behalf and regardless of my assigned health care coverage, preauthorization, predetermination or insurance benefits, I am fully responsible for the total charges for services and/or treatments rendered, and I further agree that all amounts are due upon request and are payable to the therapist.

______ *(initial)* I understand that I have/the patient has the right to privacy and that therapeutic intervention and documentation is confidential. I understand that I have the right to participate in decisions regarding the intensity and scope of treatments and can refuse treatment and be informed of the medical consequences of such a refusal. I understand I have the right to report any complaints against my/the patient's therapist or therapeutic intervention to the Texas State Board of Physical and Occupational Therapy Examiners at 333 Guadalupe, Suite 2-510, Austin, TX 78701 or Texas State Board for Speech Language Pathologists and Audiologists at 1100 West 49th Street, Austin, Texas, 78756.

______ (*initial)* I have read the illness and cancelation policy and understand I will be responsible for a no-show fee which can not be billed to my insurance. I certify that I have read, understand, and agree to the above terms and conditions.

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Patient / Legal Guardian Signature Date Relationship to Patient

Please return completed form by fax to **512-861-2355** or by email to **AnneMarie@homeCTS.com**
Please call 512-331-1999 with any insurance or billing questions.

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In Net Ded:	In Net Met:	Out Net Ded:	Out Ded Met:
In Net co%		Out Net co%	
Out Pocket Max:	Out Pocket Met:	Plan Year:	Effective date:
PT allowed	OT allowed	ST allowed	Combined allowed
PT used	OT used	ST used	Combined used

Claims address: Other:

Received:	Ins Verificaiton Ref:
Patient Contacted:	
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