IN-SYNC PEDIATRIC THERAPY CENTER

NEW PATIENT INTAKE

(Please complete and return)

Patient Name: _____

Date of Birth: _____ Patient SSN #: _____

Patient Diagnosis/Chief Complaint: _____

Address: _____

Parent/Guardian Name: _____

Home Phone: _____ Mobile Phone: _____

Email: _____

In Case of Emergency Contact Information:

Name: _____

Relationship to child: _____

Home Phone: _____ Mobile Phone: _____

Name: _____

Relationship to child: _____

Home Phone: _____ Mobile Phone: _____

Primary Care Physician: _____

PCP Phone Number: _____

PCP Address: _____

Insurance Information:

Arkansas Medicaid / SoonerCare Number: _____

Private Insurance Name: _____

Claims Address: _____

Telephone: _____

Policy Number: _____

Policy Holder's Name: _____

Policy Holder's SSN#: _____

Policy Holder's DOB: _____

- Please provide copy of Medicaid/SoonerCare and/or Private Insurance Card(s)
- Please provide copy of Driver's License

I, _____ am the contact person for all scheduling of this child's therapy times. The therapist shall contact me for any changes in therapy sessions.

I, _____ am responsible for all scheduled treatment sessions. Any scheduling changes or cancellations will be my responsibility. I have read, understand and agree to the terms of the cancellation policy that was given to me.

Please list the name and phone number of any person(s) who will be responsible for dropping off the child or picking up the child from therapy sessions (a copy of each person's driver's license will be required).

Name:_____ Phone:_____

Name:_____ Phone:_____

Name:_____ Phone:_____

Name:_____ Phone:_____

PHOTO PERMISSION: (Please initial and date)

1. I give permission for photograph/video of my child for the purposes of treatment, education, and documentation. _____ / _____

2. I give permission for photograph/video of my child to be used for advertising, brochure, internet (clinic website, Facebook, twitter, etc.) _____ / _____

I hereby give In-Sync Pediatric Therapy Center permission to evaluate and treat my child and understand there will be written, oral and electronic communication between care providers, physicians, insurance companies, and In-Sync Pediatric Therapy staff. I understand that all practices of confidentiality will be followed in use of the information gathered.

_____ _____

Signature of Parent/Guardian of Patient Date

How did you hear about us? (Please circle any and all that apply)

Physician	Phonebook
Internet Search	Friend
Website	Television
Facebook Page	Radio
Twitter	Other:_____