Special Therapies, Inc.

Assisting Development and Wellness throughout the Lifespan

CLIENT INFORMATION –

Client Name: _____ Date of Birth: _____

Home phone: _____ Cell phone: _____ Other phone: _____

Address: _____

City: _____State: _____Zip: _____

Social Security Number: _____ Marital Status: _____

e-mail address: _____

Previous treatment information (what type/where): _____

_____

IF CLIENT IS A CHILD, PLEASE COMPLETE THE FOLLOWING:

Parents or Guardians:_____

Telephone (Daytime): _____ Evening/Cell: _____

Address: _____

City: _____State: _____Zip: _____

Social Security Number of Parent or Guardian: _____

IF CHILD IS NOT LIVING WITH BOTH PARENTS, PLEASE COMPLETE THE FOLLOWING:

Custody: Joint Single Custodial Parent: _____

Name of non-custodial parent: _____

Address of non-custodial parent: _____

Telephone of non-custodial parent: _____

Has the non-custodial parent agreed to this treatment plan? Yes No Don't know

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PHYSICIAN INFORMATION

Referring Physician: _____Phone: _____

Physician Address: _____

City: _____State: _____Zip: _____

Fax: _____

*** SIGNATURE REQUIRED ON PAGE 2 ***

POLICIES AND FEES

CranioSacral Therapy Fees: $100 / hour of treatment.

Comprehensive Occupational Therapy Evaluation: $350
Basic Occupational Therapy Evaluation: $150
Occupational Therapy Fees: $120.00 / hour of individual treatment.

- Payment is required at the end of each session.
- We can submit claims on client's behalf to their primary insurance company but *do not accept assignment*. **Please note: *Special Therapies, Inc. is out of network for all private insurance companies and Special Therapies, Inc. is NOT a Medicaid provider*.**
- 24-hour notice is appreciated for all cancellations.
- **We reserve the right to charge a $25.00 fee for habitual failures to keep scheduled appointment or for non-courteous cancellations.**
- If no payment has occurred on the account for 45 days, we reserve the right to suspend therapy sessions until payment has been received.
- **If payment has not been received after 60 days, we reserve the right to add 1% interest on patient's open account.**

I agree to the above stated policies. I understand it is ultimately my responsibility to ensure funding for services received through Special Therapies, Inc. I understand that I am responsible for all debt incurred with Special Therapies, Inc.

CONSENT TO TREAT

Patient: _____ **Date of Birth:** _____

I hereby authorize Special Therapies, Inc. to perform occupational therapy evaluations, administer therapeutic treatment as recommended in the initial evaluation, and provide clinical services as deemed necessary by Special Therapies, Inc. I understand that I will receive an explanation in understandable terms of the therapy recommended for the above-named person, including possible side effects associated with treatment.

Parent/Guardian Signature: _____ **Date:** _____

Printed Name: _____ **Relationship to client:** _____

*** OFFICE USE ONLY***

DIAGNOSIS CODE(S) _____

TREATMENT CODE(S) _____