The Therapy Closet FL
450 S.R. 13 N. Suite 106
Saint Johns, FL 32259
Phone (904)329-6458 Fax (904)677-7800
www.thetherapycloset.com

PATIENT INFORMATION

CHILD'S NAME: _____

ADDRESS: _____

CITY & ZIP: _____

SS#: _____ Date of Birth: _____

NAME OF DAYCARE/SCHOOL: _____

DIAGNOSIS/MEDICAL HISTORY _____

MEDICATIONS/ALLERGIES_____

SPEECH/LANGUAGE/HEARING CONCERNS_____

PARENT/LEGAL GUARDIAN NAME(s)_____

Home PH: _____ Work PH: _____ Cell PH: _____

Email: _____

Primary Care Doctor: _____Telephone: _____

Does your child have insurance? YES NO If YES, Type (BC/BS, Cigna, Tricare) : _____

Does your child have Medicaid? YES NO

Type (CMS, Sunshine, First Coast Advantage etc.) ID# _____

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I/We the undersigned parent(s)/legal guardian of _____a minor do hereby authorize and consent to treatment performed by The Therapy Closet FL. It is understood that this authorization is given in advance of any diagnosis or treatment but is given to provide authority and power to render evaluation and further treatment if deemed necessary from licensed therapist from The Therapy Closet FL.

I authorize The Therapy Closet FL the release of medical information necessary for treatment and to process billing claims. I also authorize the payment of benefits to this provider when it accepts assignment on the claims.

This agreement will be in effect indefinitely unless the patient and/or the patients' representative decide to revoke this arrangement in writing.

I also understand that should my insurance, including Medicaid, not reimburse for services provided, that I may be responsible for payment.

PRIVATE PRACTICE ACKNOWLEDGEMENT

I give permission that the staff of The Therapy Closet FL may discuss this case with my child's teacher, center director, and/or school personnel including the Headstart Disability Specialist.

I have received and reviewed the Notice of Privacy Practices for The Therapy Closet FL.

_____ _____

Patient/Parent/Guardian Signature Date