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PEDIATRIC AND ADOLESCENT THERAPY SERVICES, LLC

Today's Date: _____

Child's Name: _____

DOB/Age: _____

Immediate Family Members:

Relationship to Child	Name	Age	Handedness

Marital Status of Parents (circle all that apply): Married Separated Divorced Other

Contact Information:

Phone: _____

E-mail: _____

Preferred form of contact (circle all that apply): Call Text E-mail

School Information:

School: _____

Grade: _____

Teacher: _____

Medical Information:

Primary Care: _____

Phone: _____

Address: _____

info@lightofminetherapy.org
918.520.6166

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Other Health Care Providers:

Name: _____

Profession: _____

Name: _____

Profession: _____

Insurance Information:

Physician Referral? Yes No

Insurance Provided: _____

*Please provide copy of Insurance Card

Other Medical:

Diagnosis: _____

Diagnostic Professional: _____

Medications: _____

Medical Precautions: _____

Known Allergies: _____

Dietary Restrictions: _____

Child Profile:

Strengths:

_____
_____
_____
_____

Interests:

_____
_____
_____
_____

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Presenting Problems (circle all that apply):

Academic Life Skills Social Sensory Motor Language Speech Emotional Play Other

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Seeking (circle all that apply): Occupational Therapy Speech Language Pathology Physical Therapy

Parent Goals:

_____
_____
_____
_____

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CONFIDENTIALITY, CONSENT TO TREAT, AND FINANCIAL POLICY

- **CONFIDENTIALITY**: All information and communication is subject to current HIPAA standards and rights for your child and family. If you want a full copy of HIPAA, please ask your therapist.
- **FINANCIAL POLICY:** Light of Mine Pediatric and Adolescent Therapy Services participates as an in-network provider with a variety of insurance companies. We must obtain a copy of the front and back of your insurance card in order to bill any therapy through your insurance. If you have any questions regarding your specific coverage of therapy assessments, trainings, treatments, or consultations, please contact info@lightofminetherapy.org.

  We will bill your insurance carrier directly if we are in network or if you agree upon your out of network terms prior to treatment begins.

  Clients will be sent a monthly bill for any member responsibility tied to your insurance benefits (copayments, coinsurances, deductibles, etc.)

  I understand that parent meetings and consultation are not covered by insurance.

- **Financial Agreement:** Clients may pay by personal check or credit card. Online payments accepted via Fusion portal. If payment by personal check is returned more than once, personal checks will no longer be accepted. If you need to cancel due to illness or other circumstances, please notify your therapist at the earliest notice possible via phone message (918.520.6166) or e-mail (info@lightofminetherapy.org)

  MY SIGNATURE INDICATES VOLUNTARY CONSENT FOR TREATMENT, CONSENT TO BILL YOUR INSURANCE COMPANY AND COLLECT PAYMENT FOR SERVICES PROVIDED, AND ACCEPTANCE OF FINANCIAL AGREEMENT AND CANCELLATION POLICY. (SIGN AND DATE).

x _____

Name, Relation to Child

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