Pediatric Therapy Associates, LLC
12122A Heritage Park Circle
Silver Spring, MD 20906

Date: _____

Patient Information

Patient Information

Patient's Name: _____ Sex: M F (circle one)

Date of Birth: _____

Home Phone: _____

Address: _____

_____

Parent Information

Parent: _____ Parent: _____

Work Phone: _____ _____

Mobile Phone: _____ _____

Email Address: _____ _____

Insured Information

First:_____Middle_____Last_____

Date of Birth: _____

Address: _____

Employer: _____

Employer Address: _____

Insurance Co.: _____ Policy Number_____

Insurance Co. Address:_____

Referring Physician

Name: _____ Phone: _____

Address: _____

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Payment Policy

1. Patient is responsible for payment at the time of the appointment.
2. PTA accepts payments from most insurance companies. Patient is responsible for co-pay, deductibles, and other expenses at the time of treatment.
3. In the event that insurance does not cover treatment or discontinues coverage, the patient is responsible for payment.
4. Therapist may recommend other types of treatment that incur additional costs. Patient is responsible for payment upon acceptance of treatment.
5. Please provide 24 hours notice for appointment cancellations. Not showing up to an appointment that has not been cancelled will be charged as a visit.
6. Please arrive on time to appointments. Arriving late to an appointment will be charged as a full appointment.

I, _____, understand and accept the above payment policies.

Signature: _____ Date: _____

Child's Name: _____

Pediatric Therapy
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Silver Spring, MD 20906

Request for Information

Please release the medical records pertaining to this child to Pediatric Therapy Associates, LLC, 12122A Heritage Park Circle, Silver Spring, Maryland 20906 or Fax to 301-942-4513.

Name: _____ Date of Birth: _____

Address: _____

_____

Email: _____

Signature: _____ Date: _____

Relationship: _____

Permission to Release Information

Permission is granted to Pediatric Therapy Associates to release physical therapy evaluations and progress reports to the following institutions and/or professionals listed below:

_____

_____

_____

Child's Name: _____

Signature: _____ Date: _____

Relationship: _____