ABC Pediatric Therapy Services
2655 Dallas Hwy. Suite 320
Marietta, GA 30064
Betsy Eager-Kessel MS-CCC-SLP, Director
Phone: (Office) 770-428-2112 (Cell) 404-556-5554
(Fax) 678-384-7495

Please Print

Date: _____

Patient Name: _____
Last First Middle

Date of Birth: _____ Male_____ Female_____

Mother: _____
Father: _____
Street Address: _____ Apt. # _____
City: _____ State: _____ Zip Code: _____
Telephone: _____ Cell: _____

Primary Care Physician: _____ Phone #_____
Physician's NPI #: _____
Address: _____
Telephone #: _____ Fax #: _____

Insurance Information

Primary Insurance: _____ PPO HMO POS
Name of Primary Insurer: _____ DOB: _____
ID #: _____ Group #: _____
Billing address on card: _____
Customer Service Telephone #: _____

Name of Secondary Insurance: _____ PPO HMO POS
Name of Secondary Insurer: _____ DOB: _____
ID #: _____ Group #: _____
Billing address on card: _____
Customer Service Telephone #: _____

If Medicaid, ID #: _____ County: _____
Patient's Name EXACTLY as it appears on Medicaid Card (please print):
_____

PLEASE LIST ANY KNOWN DRUG ALLERGIES: _____

_____

ASSIGNMENT AND RELEASE:

I, _____ have insurance coverage with_____
_____and assign directly to Betsy Eager-Kessel MS CCC-SP all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance and that all co-payments are due at the time of service. I hereby authorize the provider to release all information necessary to secure payment of benefits. I also authorize the use of this signature, as my signature, on all my insurance submissions, whether manual or electronic.

_____ _____

Signature of Insured/Parent/Guardian Date

DENTAL

Child's Dentist/location: _____

List/describe deformities of the teeth/mouth: _____

MEDICAL INFORMATION

Child/s Physician: _____

Address/Location: _____

Medical findings/diagnosis: _____

Date of last physical exam/visit: _____ Reason: _____

Current medications and reason: _____

List or briefly describe any operations with dates/locations: _____

List below any significant illnesses or medical conditions (seizure disorder; asthma; ADHD; CMV; etc.) diagnosed in the child since birth: (use back of page if more space is required)

Condition	Age	Comments
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

DEVELOPMENT

Please indicate at what age the following milestones were met:

Sitting: _____ Walking: _____ Drinking from cup: _____

Using Spoon to feed: _____ Babbling: _____

Imitation of sounds: _____ First meaningful word: _____

Two word utterances: _____ Phrases: _____ Sentences: _____

Use single words (e.g., no, mom, doggie, etc.) _____

Combine words (e.g., me go, daddy shoe, etc.)_____

Name simple objects (e.g., dog, car, tree, etc.)_____

Use simple questions (e.g. where's doggie? etc.)_____

Engage in a conversation: _____

Does child have difficulty walking, running, or participating in other activities which require small or large muscle coordination?

Are there or have there ever been any feeding problems (e.g. problems with sucking, swallowing, drooling, chewing etc.?) If yes, describe.

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Authorization for Use or Disclosure of Information
For Purpose Requested by Therapist

In this document, "I" and "my" refer to the patient
And "Therapist" refers to ABC Pediatric Therapy Services, Inc.

I hereby authorize Therapist to (check those that apply)
____/____ use the following protected health information, and/or
_____ disclose the following protected health information to the following entity:

Pediatrician & Insurance Company

This protected health information is being used or disclosed for the following purposes:

Reimbursement purposes

This Authorization shall be in force and effect until _____, at which time this Authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to the Privacy Officer of the Therapist, at 2655 Dallas Highway, Suite 320, Marietta Georgia 30064. I understand that revocation is not effective to the extent that Therapist has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Therapist will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefit (if applicable) on whether I provide Authorization for the requested use of disclosure.

I understand that I have the right to inspect or copy the protected health information to be used or disclosure as permitted under federal law (or state law to the extent the state law provides greater access rights) and/or to refuse to sign this Authorization. I understand that the use or disclosure required under this Authorization may result in direct or indirect remuneration to Therapist from a third party.

_____ _____
Signature of Patient or Personal Rep — Printed Name of Patient

_____ _____
Date of Signing — Description of Personal Rep.'s Authority

ABC Pediatric Therapy Services, Inc.
Betsy Eager-Kessel MS CCC-SP

Consent for Purposes of Treatment, Payments & Healthcare Operations

In this document, "I" and "my" refer to the patient,
and "Therapist" refers to Learning & Communication Services

I consent to the use or disclosure of my protected health information by Therapists for the purpose of analyzing, diagnosing or providing treatment to my child, obtaining payment for my healthcare bills, or to conduct healthcare operations of Therapist. I understand that analysis, diagnosis or treatment of my child by Therapist may be condition upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Therapist is not required to agree to the restrictions that I may request. However, if Therapist agrees to a restriction that I request, the restriction is binding on Therapist. I have the right to revoke this consent in writing, at any time, except to the extent that Therapist has taken action in reliance on this Consent.

My "protected health information" means health information, including demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition, and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Therapist and understand that I have a right to a copy of the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of Therapist. The Notice of Privacy Practices for therapist is also posted in the waiting room at 2655 Dallas Highway, Suite 320, Marietta Georgia 30064. This Notice of Privacy Practices also describes my rights and duties of the Therapist with respect to my protected health information.

Therapist reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office of the Therapist and requested a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Rep Printed Name of Patient

_____ _____

Date of Signing Description of Personal Rep.'s Authority