# The Children's TherAplay Foundation, Inc.
# 2020 Patient Information

Client's Name: ____________________ Soc. Sec. # ____________________

Nickname: ____________________ DOB: ____________________

Home Address: ________________________________________

City, State Zip: ____________________ County: ____________________

Home Phone: ____________________ ☐ Male ☐ Female

Has any of the above contact information changed since last year? ☐ Yes ☐ No

**Parent/Guardian Information**

**Guardian 1 Name**: ________________________________________

Soc. Sec. # ____________________ DOB: ____________________

Address (if different than above): ________________________________________

City, State Zip: ____________________ County: ____________________

Place of Employment: ________________________________________

Home Phone: ____________________ Cell Phone: ____________________

Work Phone: ____________________ E-mail Address: ____________________

**Guardian 2 Name:** ________________________________________

Soc. Sec. # ____________________ DOB: ____________________

Address (if different than above): ________________________________________

City, State Zip: ____________________ County: ____________________

Place of Employment: ________________________________________

Home Phone: ____________________ Cell Phone: ____________________

Work Phone: ____________________ E-mail Address: ____________________

Caregiver Name: ____________________ Relationship: ____________________

Home Phone: ____________________ Cell Phone: ____________________

**In case of an emergency, who should we contact?**

Name: ____________________ Relationship: ____________________

Home Phone: ____________________ Cell Phone: ____________________ Work Phone: ____________________

**❑ I attest that I have received a copy of the Discharge and Attendance Policies. I also have reviewed my personal information and understand that I am responsible for updating any changes in my insurance benefits. Starting January 1st, 2020 I acknowledge that $50.00 will be collected towards my deductible until it has been met. Further charges will be billed on a monthly basis until my deductible has been met.**

***— Continued on next page —***

## Medical History Information

Please list your child's **current** referring physician: _____________________________________________________________

Phone: ____________________________________________ Fax: ___________________________________________________

Current therapies: ___________________________________________________________________________________________

_____________________________________________________________________________________________________________

Precautions/restrictions (i.e. seizures, respiratory problems, swallowing, allergies, sensitivities, etc.): ________________

_____________________________________________________________________________________________________________

Current medications: ________________________________________________________________________________________

_____________________________________________________________________________________________________________

Surgeries (in last year): _____________________________________________________________________________________

_____________________________________________________________________________________________________________

Current equipment: __________________________________________________________________________________________

_____________________________________________________________________________________________________________

## Insurance Information

**We **must** have your most current insurance information. This could affect your child's treatment.
Please list ALL your current insurance name(s), policy, and group numbers.

| **Primary** | **Secondary** | **Tertiary** |
|---|---|---|
| Company | Company | Company |
| Insured's Name | Insured's Name | Insured's Name |
| Policy # | Policy # | Policy # |
| Group # | Group # | Group # |
| Provider Services Phone No. | Provider Services Phone No. | Provider Services Phone No. |

The 2020 Patient Information Update is not complete until all your insurance cards have been copied and verified. To ensure continuation of services, please remember to present your insurance cards at the main office by 6 p.m. January 10th, 2020. Haven't received your insurance card yet? Please see page 3.

*--- Continued on next page ---*

Client Name: ___________________________

*This page is only required for those patients who have not yet received their 2020 insurance cards.*

**If you have received your insurance card, please skip to page 4.**

**If you haven't received your new insurance card yet, please be sure to complete this page.**

You can ensure continuation of your child's services by contacting your insurance carrier, either through their Member Services phone line or by logging in to their website, for the following information.

Insurance company: ___________________________________________________________

Insured's name: ______________________________________________________________

Policy #: _____________________________________________________________________

Group #: ____________________________________________________________________

Provider services (*not* member services) phone number: ____________________________

Mailing address to file claims: ______________________________________________

_____________________________________________________________________________

*--- Continued on next page ---*

Client Name: ____________________________

# HIPAA Release of Information Form

1. By signing below, I hereby authorize my child's Protected Health Information to be disclosed. The Protected Health Information I am authorizing for disclosure is the following:
   - ☐ "Standard" release of information (Includes evaluation, daily therapy notes and progress notes, all billing records, etc. )
   - ☐ Specific information from my child's chart: ______________________________________________

   ____________________________________________________________________________________

   ____________________________________________________________________________________

2. The person or group of people who are authorized to disclose my child's Protected Health Information are as follows: any healthcare provider and/or employee of The Children's TherAplay Foundation, Inc.

3. I hereby request The Children's TherAplay Foundation, Inc. to disclose my child's Protected Health Information to the following person(s) or institutions(s):
   - ☐ Name and address of person or parties to receive your child's medical information:

   ____________________________________________________________________________________

   ____________________________________________________________________________________

   ____________________________________________________________________________________

4. This authorization will expire 365 days from signing unless an earlier date is indicated. ____________

5. I understand that I have the right to revoke this Authorization, if the revocation is in writing, except if:
   The Children's TherAplay Foundation, Inc. has taken action in reliance upon this Authorization.
   or, if this Authorization was given as a condition of obtaining insurance coverage, other law provides that the insurance company has the right to contest a claim under the insurance policy.

6. I understand that I may revoke this Authorization by sending a written request to:
   The Children's TherAplay Foundation, Inc.    9919 Towne Road    Carmel, IN 46032

7. I understand that my child's Protected Health Information that is disclosed under this Authorization may be subject to re-disclosure by the recipient, and the privacy of my Protected Health Information will no longer be protected by the law.

   By signing this Authorization, I acknowledge that I have read and understand this Authorization. Further, I authorize the disclosure of my child's Protected Health Information in accordance with the terms of this Authorization.

_________________________________________    ________________________________

Signature of Parent or Guardian    Date

____________________________________________________________________________

Name & Relationship to Patient

*--- Continued on next page ---*

## *Optional*

As a United Way of Central Indiana partner agency, we are required to request the following information.

### Clients Served by the Agency

First Name: ________________________________ Last Name: ____________________________

Date of Birth: _______________________________ Age: __________________________________

Home Address Street: _________________________________________________________________

City: _______________________________________ ZIP Code: ____________________________

Gender: ____________________________________ Race: __________________________________

Ethnicity - Hispanic or Latino Origin: ___________________________________________________

Number in Household: ________________________________________________________________

Household Income: $0.00 - $25,000.00 ☐
$25,000.00 - $50,000.00 ☐
$50,000.00 - $100,00.00 ☐
$100,000.00+ ☐

School District Child Attends: __________________________________________________________

School Child Attends: _________________________________________________________________

Child's Grade Level: _________________________ Anticipated HS Graduation Year: _________

***Thank you!***
***Remember to return all five pages to the Children's TherAplay main office, email them to info@childrenstheraplay.org (not your therapist), or fax them to (317) 872-3234 by 6 p.m. on Friday, January 10th, 2020.***