The Children's TherAplay Foundation, Inc.

New Patient Form – ALL FIELDS REQUIRED

Date: _____ How did you hear about Children's TherAplay? _____
Referral for (please check): □ Physical Therapy □ Occupational Therapy
Patient Name: _____ DOB: _____
Diagnosis: _____ Weight: _____ Height: _____
Can patient sit independently? □Yes □No Walk independently? □Yes □No
What therapies does patient currently receive? _____ Location: _____
Date of last PT/OT evaluation: _____ Location: _____

Preferred Times for therapy appointments: _____ AM _____ PM
□ Monday □ Tuesday □ Wednesday □ Thursday □ Friday (please check **ALL** options)

Family Goals for Patient:

Parent/Guardians: _____
Address: _____
City, State, Zip: _____
Home Phone: _____ Cell: _____ E-mail: _____

Referring Physician: _____
Physician's Medical Group: _____
Physician's Address: _____
MD Phone: _____ MD Fax: _____
Referring Therapist: _____ Phone: _____

Insurance: Please check ALL that apply

□ Medicaid □ Children's Special Health Care Services □ Self-Pay □ Private Insurance

Medicaid Case Manager: _____ Phone: _____ Fax: _____
Type of MCD: □ Traditional □ Waiver □ Risk Based Managed Care

Client's RID #: _____ Effective Date: _____

CSHCS: ID #: _____ Effective Date: _____

Private Insurance:
Company: _____
Insured's Name: _____ DOB: _____
Policy#_____ Group #_____
Provider Services Phone Number (on back of card) _____

Please be sure to inform us of ANY changes in your insurance. Failure to do so may result in patient responsibility for the entire billable amount.

Please return this form to Teresa Keathley at tkeathley@childrenstheraplay.org

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