PATIENT INTAKE INFORMATION

Please Print

Patient:

Last Name ____ First ________________________________ Middle________________________

Male Female DOB: ______________________________ SSN _________________________________

Address: Street 1____ Street 2 ____

City ____ State___________________________ Zip____________________________

Phone: Home ___________________________________ Cell ___________________________________

Email: ____

□ **I would like appointment reminders and/or other communication.** Circle desired: **Text**-provide carrier name_______________ **Email** (provide above)

Medical Details:

Primary Diagnosis: ____Onset Date: _____________________

Secondary Diagnosis: ____Onset Date: _____________________

Referring Physician: ____ Phone Number:____________________________

Primary Care Physician (if different): ____

Practice Name: ____ Street ____

City ____ State___________________________ Zip______________________________

Phone: ____ Fax ___________ ____

Pertinent Medical Information (allergies, medications, etc.) ____

____

Parent or Guardian Information:

Mother/Guardian: ____ DOB:___________ Phone Number:__________________________________

Address:____

Father/Guardian:____ DOB:____________ Phone Number:__________________________________

Address:____

~ Please inform the office of any disclosure restrictions related to patient's custody/care.

Insurance subscriber's contact info

Name: ____ Street: ____

City ____ State___________________________ Zip_____________________________

Phone: Home __________________________________ Cell ___________________________________

Email: ____

PATIENT INTAKE INFORMATION

Please Print

Insured's Employer: Company Name: ______________________________

Street 1 ______________________________ Street 2 ______________________________

City ______________________________ State______________ Zip______________

Phone______________________________ Email______________________________

Patient's School: School Name: ______________________________

School City and County: ______________________________ Attends: Full Time Part Time

Attestation Regarding IEP/IFSP for Outpatient Therapy Services

Certain patients with Medicaid coverage that attend a school may have an **Individualized Educational Plan** (IEP) or an **Individualized Family Service Plan** (IFSP). We are obligated to submit a copy of this document for Medicaid recipients.

☐ **By initialing this box the undersigned confirms that the patient DOES NOT have an IEP or an IFSP at this time. Inform us immediately if patient obtains IEP/IFSP. Failing to do so may cause denial of payment from insurance therefore making you financially responsible.**

☐ **By initialing this box the undersigned confirms that the patient DOES have an IEP or an IFSP and agrees to provide a copy to Walker Therapy Services. □ I allow the school to bill Medicaid for my child's therapy. □ I do not allow the school to bill Medicaid for my child's therapy.**

The undersigned authorizes Walker Therapy Services and the named school system to share patient's medical and treatment information for TPO.

Insurance: ***Claim submission order will be Commercial first. Commercial carriers do not include Medicaid.***

Primary **Commercial** Carrier: ______________________________

Insured's Name: ______________________________ Insured's SSN______________________________

Insured's DOB: ______________ Group # ______________ ID # ______________ Co-Pay $ __________

☐ **By initialing this box the undersigned confirms that the patient has no COMMERCIAL insurance coverage at this time.**

Secondary **Commercial** Carrier:______________________________

Insured's Name: ______________________________ Insured's SSN______________________________

Insured's DOB: ______________ Group # ______________ ID # ______________ Co-Pay $ __________

☐ **By initialing this box the undersigned confirms that the patient has no secondary COMMERCIAL insurance coverage at this time.**

PATIENT IS AN AUTHORIZED MEDICAID RECIEPIENT: circle one**: FFS Medicaid Amerigroup PeachState** __________

Medicaid ID Number ______________________________ CMO ID Number ______________________________

Circle or fill in patient's **Medicaid Type**: Deeming Waver SSI Foster Child Adoption Assistance CMS______________

PATIENT IS IN THE BABIES CAN'T WAIT PROGRAM: My cost participation __________%

Current IFSP Date: ______________________________

Service Coordinator: ______________________________ Phone: ______________ County ______________

PATIENT INTAKE INFORMATION

Please Print

Emergency Contact Information:

Primary Contact Name: ____ Contact Phone #: __________________________________

Alternate Phone #: _________________________________

Secondary Contact Name: ____ Contact Phone #: _________________________________

Alternate Phone #: _________________________________

In case of an emergency, the undersigned authorizes Walker Therapy Services, LLC to seek treatment for the patient until such time that the undersigned or another legal guardian can be present.

Other Therapist Contact Information:

Walker Therapy Services, LLC, is hereby authorized to share and exchange medical and treatment information regarding the patient with the below named individuals and companies who may also render therapy services to the patient.

Name ____ OT PT SLP Other______________________

Company Name: ____ Address 1: ____

Address 2: ____________________________________ City: ____ State: __________ Zip: ________________

Phone: ____ Fax: ____

Name ____ OT PT SLP Other______________________

Company Name: ____ Address 1: ____

Address 2: ____________________________________ City: ____ State: __________ Zip: ________________

Phone: ____ Fax: ____

Name ____ OT PT SLP Other______________________

Company Name: ____ Address 1: ____

Address 2: ____________________________________ City: ____ State: __________ Zip: ________________

Phone: ____ Fax: ____

____

Signature: Patient or Agent/Guardian/Representative

____

Date

____

Printed name of Patient's Agent/Guardian/Representative

____

Agent/Guardian/Representative Relationship to Patient