# Today's Therapy Solutions

**5500 N Western, Suite 153 OKC, OK 73118**
**Phone: (405) 286-3749 Fax: (866) 435-3297**
**www.todaystherapysolutions.com**

**CLIENT INFORMATION**: Today's Date _____

Name _____ Date of Birth _____
Address _____ City _____ State/Zip _____
Phone Number (home) _____ (work/cell) _____
Diagnosis _____ Social Security Number _____
Physician _____ Phone number _____
Address _____ City/State/Zip _____

**PRIMARY CONTACT** (the person to call for scheduling apts. & additional info.)
Mother's name _____ Father's name _____
Telephone (home) _____ (work/cell) _____
Address _____ City/State/Zip _____

**PERSON MAKING THE REFERRAL** (the person who told you about TTS)
Name _____ Relationship _____
Telephone (home) _____ (work/cell) _____
Address _____ City/State/Zip _____

**What type of services are needed?** (check all that apply)
___Speech Therapy ___Physical Therapy ___Occupational Therapy
___Neuropsychological Eval. ____Behavior Therapy

**What activities would this client like to do that he/she is unable to currently do?**

_____
_____
_____

**PLEASE CONTINUE ON THE OTHER SIDE….**

☐ **INSURANCE ONLY (In-Network)**

If we are **in network** with your insurance company, we will process those claims and then bill you for the unpaid balance. You are responsible for contacting your insurance company for coverage amounts.

*Current Deductible Amount Owed $_____ Today's date_____
**Co-pay due for each session $_____
Insurance Company_____
Name of person listed as policy holder _____
Insurance ID#_____ Group #_____
***We must have a copy of the front & back of your insurance card prior to the start of services***

*Your deductible is the amount you must pay before your insurance company will begin paying for or 'covering' your child's therapy. **This will be charged to your credit/debit card for each visit.**

**Your Co-Pay is the amount you must pay at each visit after you have met your deductible. **This will be charged to your credit/debit card for each visit.**

☐ **SELF PAY**

If we are **not in-network** with your insurance company or you do not have private insurance, you are considered a self pay client. **You are responsible for all charges**.

We will bill your credit/debit card twice monthly (1st & 3rd Friday of each month). **Our office will contact you to receive credit/debit card information.** A statement will be sent monthly containing the amounts charged.

Self Pay **ONLY** (name on the credit card)_____

Credit card billing address _____

_____

**CREDIT CARD AUTHORIZATION AGREEMENT:**

I hereby authorize Today's Therapy Solutions to charge my credit/debit card twice monthly for therapy/assessment services provided during the billing period. It is my responsibility to update Today's Therapy Solutions with any changes to my credit card information. I am responsible for any service charges accrued by Today's Therapy Solutions due to the denial of my credit card **AND** agree to pay a service fee of **$20**.

_____ _____
Signature Date

_____
Printed Name of Signee