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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