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[www.todaystherapysolutions.com](http://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 \_\_\_\_\_

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**PRIMARY CONTACT** (the person to call for scheduling appts. & additional info.)

Mother's name \_\_\_\_\_ Father's name \_\_\_\_\_  
Telephone (home) \_\_\_\_\_ (work/cell) \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

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**PERSON MAKING THE REFERRAL** (the person who told you about TTS)

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Telephone (home) \_\_\_\_\_ (work/cell) \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

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**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....**

**PAYMENT POLICIES** (Please check which applies)

☐ **SOONERCARE/MEDICAID ONLY:** Our office will process your child's claims directly to Medicaid. It is your responsibility to **obtain a prescription from your doctor for services requested and provide us with a current IEP (if applicable). You must also keep us informed of any changes in your child's status (Medicaid coverage/change of physician).**

Name as printed on Soonercare/Medicaid Card \_\_\_\_\_  
Soonercare/Medicaid Number \_\_\_\_\_

☐ **PRIVATE INSURANCE PLUS MEDICAID (TEFRA):** Our office will process claims to your insurance company first. The insurance company will send out an Explanation of Benefits (EOB). **These are vital! We must have the EOBs in order to process claims to Medicaid.** When you receive an EOB, you are responsible for sending them to our office. You may do this through email (Todaystherapy@gmail.com), fax (1-866-435-3297), by mail or in person. Delays in forwarding the EOBs to our office may result in your child's services being put on hold.

Insurance Company \_\_\_\_\_  
Name of person listed as insurance carrier \_\_\_\_\_  
Insurance ID# \_\_\_\_\_ Group # \_\_\_\_\_

**\*\*\*We must have a copy of the front and back of your insurance card prior to start of services\*\*\***

Name as printed on Soonercare/Medicaid Card \_\_\_\_\_  
Soonercare/Medicaid Number \_\_\_\_\_

By signing below, you state that you understand the payment policy that pertains to you & are responsible for payment as outlined above.

\_\_\_\_\_  
Signature of Guardian/Insurance Carrier

\_\_\_\_\_  
Date