

CREATIVE THERAPY, INC

#1 McGarity Road

Canton, GA 30115

770 360-9183 fax 770 360-8965

Patient Name _____ **Date of Birth** _____

Address _____

Phone _____ **E-mail** _____

Social Security # _____

Primary Diagnosis _____

Secondary Diagnosis _____

Referring Physician _____

INSURANCE INFORMATION

Primary Insurance _____

Address _____

Phone # _____

Policy Holder _____

Date of Birth _____

Policy # _____ **Group #** _____

Secondary Insurance _____

Address _____

Phone # _____

Policy Holder _____

Date of Birth _____

Policy # _____ **Group #** _____

Other OT or PT providers - are they billing medicaid? _____

(Please attach an enlarged copy of your insurance card, front and back; and medicaid form, if applicable)

*** I authorize the release of any information necessary to process insurance claims.**

*** I authorize the payment of insurance claims to be released to Creative Therapy, Inc.**

*** I understand I am financially responsible for claims not paid by insurance for services provided by Creative Therapy, Inc.**

Parent/Guardian: _____ **Date:** _____

CREATIVE THERAPY, INC.
#1 McGarity Road
Canton, GA 30115
770-360-9183
770-360-8965 (fax)
Tax ID # 58-2473143

MEDICAID REIMBURSEMENT

I, _____, understand that Medicaid allows a maximum of 8 units
Name of Parent or Guardian

(2 hours) per month per specialty with or without prior approval. I understand that in the event all my services were met by other providers, I am accepting full financial responsibility and will pay for all services provided by Creative Therapy, Inc.

Patient Name: _____ Date of Birth: _____

Parent or Guardian Signature: _____ Date: _____

AUTHORIZATION FOR COMMUNICATION WITH OTHER TREATMENT PROVIDERS

I, _____, authorize Creative Therapy, Inc. to communicate
Name of Parent or Guardian

with the following physicians, therapists, and/or companies to facilitate communication regarding therapy or reimbursement issues, including Medicaid Prior Approval:

Provider Name Address and Phone Number

Physician(s): _____

Therapist(s) or Company: _____

Parent or Guardian Signature: _____ Date: _____

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ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____, on behalf of _____
(Parent's Name) (Child's Name)

have received a copy of Creative Therapy, Inc.'s Notice of Privacy Practices with an effective date of April 14, 2003.

Name of Patient: _____

Address of Patient: _____

Signature of Parent/Legal Guardian: _____ Date: _____
Parent/Legal Guardian

Signature of Therapist: _____ Date: _____
Therapist