Therapy Tree
Center for pediatric feeding disturbances
311 West Spring Street Fayetteville, Ar 72701 **tel:** 479-301-5754 **fax:** 1-866-643-9041

PATIENT INFORMATION FORM

PATIENT NAME: _____ **DATE**: _____

ADDRESS: _____ **DOB**: _____

CITY: _____ **NC ZIP**: _____ **EMAIL**: _____

PARENT / GUARDIAN NAME: _____

HOME PHONE: _____**WORK**: _____ **CELL**: _____

PEDIATRICIAN: _____ **PHONE**: _____

PRACTICE NAME: _____ **FAX #**: _____

WHO MAY WE THANK FOR THIS REFERRAL? _____

INSURANCE COMPANY: _____

I.D. # _____ GROUP #: _____

POLICY HOLDER: _____ EMPLOYER: _____

POLICY HOLDER'S DOB: _____

CLAIMS ADDRESS: _____

HAS DEDUCTIBLE BEEN MET? YES_____ NO_____ AUTH REQ'D? _____

COPAY AMOUNT $_____ AND / OR _____%

MEDICAID I.D. #_____ EXPIRATION:_____

BY SIGNING BELOW I AGREE THAT:

• Payments for all professional services rendered are the responsibility of the patient regardless of coverage by insurance.

• I have been informed of and will adhere to the **Cancellation Policy.**

• Insurance Authorization: I hereby authorize **Therapy Tree, LLC** to furnish information to

insurance carriers concerning my evaluations and therapy and I hereby assign payment to

Therapy Tree, LLC for services rendered to my dependent. I understand that I am financially responsible for any amount not covered by my insurance.

• I give my permission to allow **Therapy Tree, LLC** to email any pertinent forms pertaining to my child at the above email address listed.

Signature: _____ Date: _____

Relationship to patient: _____