Home Therapy
Resources Inc

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Tulsa, OK 74145
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www.hometherapyresources.com

New Patient Form

Date: _____ **Referred By:** _____

Patient's Name: _____ **DOB:** _____

Age: _____ **Sex:** ____ **Home Phone:** _____ **Cell Phone:** _____

Street Address: _____

City/State/Zip: _____ **Email:** _____

Responsible Party: **Father**_____ **Mother**_____ **Other** _____

Responsible Party Name: _____

Street Address: _____

City/State/Zip: _____ **Home Phone:** _____

Cell Phone: _____ **Work Phone:** _____

Emergency Contact: _____ **Relation:** _____ **Phone:** _____

Primary Care Physician: _____

Physician Location: _____

Phone: _____ **Fax:** _____

Date last seen by PCP: _____ **Diagnosis:** _____

Please indicate if your child has received therapy services within the past 12 months:

☐ **Occupational Therapy** **Date of Last Eval:** _____ **Clinic:** _____
☐ **Physical Therapy** **Date of Last Eval:** _____ **Clinic:** _____
☐ **Speech Therapy** **Date of Last Eval:** _____ **Clinic:** _____

Insurance Information (*Please furnish a copy, front & back, of insurance card)*

PRIMARY INSURANCE: _____

Insured's Name: _____ **DOB:** _____ **SSN:** _____

ID#: _____ **Group #:** _____

SECONDARY INSURANCE: _____

Insured's Name: _____ **DOB:** _____ **SSN:** _____

ID#: _____ **Group #:** _____

PAYMENT METHOD for COINSURANCES, COPAYS, or DEDUCTIBLES:

___Email my invoices so I can access link to pay with echeck or credit card
___Mail my invoices so I can send a check
___Mail my invoices so I can call in my credit card information
___Swipe my credit card at the time of service

PLEASE REVIEW FINANCIAL POLICIES, SIGN AND DATE

Home Therapy Resources, Inc. appreciates you selecting us to meet your child's therapy needs. These services imply a financial responsibility on your part. ***Home Therapy Resources, Inc.*** will verify your coverage/benefits and bill your insurance carrier on your behalf. However, it is ultimately your responsibility for the payment of al services received.

You are responsible for payment of any co-payments at the time of services. You are also responsible for payment of deductibles and/or co-insurance upon receipt of a bill from ***Home Therapy Resources, Inc.*** If you do not have insurance, it is expected that all fees will be paid on a regular basis before therapy visits as determined by ***Home Therapy Resources, Inc.*** A discount will be provided if you do not have insurance coverage. ***Home Therapy Resources, Inc.*** understands special needs. If special arrangements are needed, please contact our office at 918-806-0106 to discuss the matter with our billing department as soon as possible so specific arrangements can be agreed upon. If you have any questions, please feel free to ask. We are here to help you.

I authorize ***Home Therapy Resources, Inc.*** to receive payment of all therapy benefits to which I or my child is entitled, including Soonercare and Private Health insurance for occupational, physical and speech therapy services. I have had an opportunity to read and understand the Financial and Health Insurance Policy Statement of ***Home Therapy Resources, Inc.*** and am agreeable to all the policies stated. I understand my responsibility for full and prompt payment on my account.

Signature:_____ **Date:** _____

Relationship to Patient: _____