

## The Children's TherAplay Foundation, Inc. New Patient Form – ALL FIELDS REQUIRED



Referral for (please check): Physical Therapy Occupational Therapy   Patient Name:	Date:	How did you he	ar about Childro	en's TherAplay? _			
Patient Name: DOB;		•					
Diagnosis:		, i	, I	10	DB:		
Can patient sit independently? D'Yes DNO Walk independently? D'Yes DNO What therapies does patient currently receive? Location: Date of last PT/OT evaluation: Location: Preferred Times for therapy appointments: AMPM Donday Duesday DWednesday DThursday DFriday (please check ALL options) Family Goals for Patient: Parent/Guardians:							
Date of last PT/OT evaluation: Location:PM	-			•		0	
Date of last PT/OT evaluation: Location:PM	What therapies does patient	currently receive?		Locati	on:		
Preferred Times for therapy appointments: AM PM PM PM Monday Tuesday Wednesday Thursday Friday (please check ALL options) Family Goals for Patient: Address: Address: Address: Address: Cell: E-mail: Pm Phone Phone: Cell: E-mail: Physician's Address: MD Fax: MD Fax: Physician's Address: MD Fax: Phone: Fax: Phone:		-					
Monday       Tuesday       Thursday       Friday (please check ALL options)         Family Goals for Patient:       Friday (please check ALL options)         Parent/Guardians:							
Family Goals for Patient:         Parent/Guardians:         Address:	Preferred Times for therapy	appointments:	AM	PM			
Parent/Guardians:	$\Box$ Monday $\Box$ Tuesday	🗆 Wednesday	🗆 Thursday	□ Friday (pleas	e check <b>AL</b>	L options)	
Address:	Family Goals for Patient:						
Address:							
Address:							
Address:	Parent/Guardians:						
City, State, Zip:Cell:E-mail:	Address:						
Referring Physician:							
Physician's Medical Group:	Home Phone:	Cell:		E-mail: _			
Physician's Medical Group:	Referring Physician:						
Physician's Address:	Physician's Medical Group:						
MD Phone: MD Fax: Referring Therapist: Phone: Phone: Phone: Fax: Insurance: Please check ALL that apply • Medicaid Case Manager: Phone: Fax: Type of MCD: • Traditional • Waiver • Risk Based Managed Care Client's RID #: Effective Date: CSHCS: ID #: Effective Date: Private Insurance: Company: Insured's Name: DOB: Policy# Group #	Physician's Address:						
Referring Therapist:Phone:   Insurance: Please check ALL that apply   Image: Medicaid   Children's Special Health Care Services Self-Pay   Private Insurance   Medicaid Case Manager:   Phone:   Phone:   Phone:   Private Insurance   Medicaid Case Manager:   Phone:   Phone:   Private Insurance   Client's RID #:   Private Insurance   CSHCS:   ID #:   Effective Date:   Private Insurance:   Company:   Insured's Name:   Policy#   Policy#							
Medicaid Case Manager: Phone: Fax: Medicaid Case Manager: Phone: Fax: Type of MCD:  Traditional  Waiver  Risk Based Managed Care Client's RID #: Effective Date: CSHCS: ID #: Effective Date: Private Insurance: Company: DOB: DOB: Policy# Group #							
Medicaid Case Manager: Phone: Fax: Medicaid Case Manager: Phone: Fax: Type of MCD:  Traditional  Waiver  Risk Based Managed Care Client's RID #: Effective Date: CSHCS: ID #: Effective Date: Private Insurance: Company: DOB: DOB: Policy# Group #	Insurance: Plazes check AI	[ that apply					
Medicaid Case Manager: Phone:   Type of MCD: Traditional   Waiver Risk Based Managed Care   Client's RID #: <b>CSHCS:</b> ID #: <b>Effective Date: Effective Date: CSHCS:</b> ID #: <b>Private Insurance:</b> Company: <b>DOB:</b> Policy# <b>DOB: Group</b> #	<u>Insulance.</u> I lease check <i>I</i> Lh	L that apply					
Type of MCD:  Traditional  Waiver Risk Based Managed Care Client's RID #:Effective Date: CSHCS: ID #:Effective Date: Private Insurance: Company: Insured's Name: DOB: Policy#Group #	□ Medicaid □ Children	n's Special Health (	Care Services	□ Self-Pay □	Private Ins	surance	
Type of MCD:  Traditional  Waiver Risk Based Managed Care Client's RID #:Effective Date: CSHCS: ID #:Effective Date: Private Insurance: Company: Insured's Name: DOB: Policy#Group #	Medicaid Case Manager:		Phone:		Fax:		
Client's RID #: Effective Date:         CSHCS:       ID #:         Private Insurance:         Company:         Insured's Name:         Policy#	Ũ						
CSHCS:       ID #:         Private Insurance:          Company:          Insured's Name:       DOB:         Policy#       Group #				C C			
Private Insurance:           Company:           Insured's Name:           Policy#           Group #	Client's RID #:	Effective Date:					
Company:	<u>CSHCS:</u> ID #:	Effective Date:					
Insured's Name:         DOB:           Policy#         Group #	Private Insurance:						
Insured's Name:         DOB:           Policy#         Group #	Company:						
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Please be sure to inform us of ANY changes in your insurance. Failure to do so may result in patient responsibility for the entire billable amount.

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