Synaptic Pediatric Therapies, LLC.
Office: (972) 454-9309
Fax: (972) 338-9378
Info@SynapticPediatricTherapies.com
SynapticPediatricTherapies.com

Patient Information & Consent Form

Name: _____
Today's Date: _____
Date of Birth: _____

Sex: ☐ Male ☐ Female

Preferred contact method:

☐ Home Phone: _____
☐ Work Phone: _____
☐ Cell Phone: _____
☐ E-mail: _____

Address: _____
City: _____ State: _____ Zip: _____
Social Security Number: _____
Parent Name: _____
Parent Employer: _____
Primary Care Physician's Name: _____

How did you hear about this practice?

☐ Doctor
☐ Friend/Family Member
☐ Google / Yelp / Facebook Other
☐ (Insurance Website, etc...)

Insurance Information

Please email a copy/photo of insurance card to info@SynapticPediatricTherapies.com or bring with you to the evaluation appointment!

Primary Insurance: _____

Member ID: _____

Group Number: _____

Phone Number: _____

Secondary Insurance: _____

Member ID: _____

Group Number: _____

Phone Number: _____

Payment Policy: Co-pays and Co-insurances are due at the time of service, or full payment is due for self-pay patients unless prior arrangements have been made with our billing department. We accept cash or credit cards (Visa, MasterCard and Discover). On a limited basis checks may be accepted and there is a service charge on any returned check; payment in full will be required within 10 days of notice.

Insurance: Our office will kindly bill your insurance company. We participate with a number of medical insurance plans that we will contact to verify eligibility and benefits. Please realize that you have the ultimate responsibility of verifying the coverage with your insurance. You acknowledge that we may be an out of network provider with your insurance. You are also aware that in some circumstances your insurer will send payment directly to you. You agree to endorse the insurance check and forward funds to the appropriate entity above within 30 days of receipt. You will be responsible for any balance not paid or denied by your insurance carrier. Patients who do not supply accurate insurance information will be considered self-pay. You must inform our office of any changes in your insurance, as you are the policyholder and it is your responsibility.

☐ The above information on all pages of this document is thorough and accurate to the best of my knowledge. For any changes to the above information, I will notify the office.

☐ I consent to evaluation and treatment by any provider at Synaptic Pediatric Therapies. I hereby authorize release of medical information that is necessary for my further treatment.

☐ I authorize release of information, including treatment and protected health information to my insurance company that is needed to process payment for services. I authorize my insurance carrier to pay benefits for services rendered, directly to Synaptic Pediatric Therapies LLC, or any of its affiliates. I have read and agree to the terms of the above information.

_____

Name of Person Completing This Form

_____

Relationship to Patient