Admission Form

Patient Demographic and Relevant Medical Information:

First Name:	Middle:	Last Name:	DOB:
Nickname:	Age:	Sex:	SSN:
Physical Address:			
City:	State:	Zip Code:	If patient mailing address differs from physical address, please report additional information.
Diagnosis:		Diagnosis Date:	
Diagnosing Physician:			
Diagnosing Physician Practice Name:			
Primary Care Physician (PCP):		PCP Start Date of Care:	
Primary Care Physician Practice Name:			
Referring Physician:			
Date of Referral:			
Medication Allergies:			
Food or Environmental Allergies:			

Primary Billing Information (Please submit a copy of front and back of all insurance cards):

Person responsible for payment:	
Insurance Provider:	Policy Number:
Name of Policy Holder:	Relationship to Patient:
Policy Holder's Social Security Number:	
Policy Holder's Employer:	

Secondary Billing Information (if applicable):

Person responsible for payment:	
Insurance Provider:	Policy Number:
Name of Policy Holder:	Relationship to Patient:
Policy Holder's Social Security Number:	
Policy Holder's Employer:	

Parental Demographic Information:

Father's Last Name:			First:		Middle Initial:	
Title: Dr. Mr.	Name Suffix:	Age:	Is this individual the biological father of the patient?			
Social Security Number:			Date of Birth:			
Sign attesting you are legal guardian for patient:						
Does this individual reside with patient:		Yes – Full Time	Yes – Part Time	No	Other	
Physical Address:				Martial/Legal Status:		
City:	State:	Zip Code:	If mailing address differs from physical address, please report additional information.			
Cell Phone:			Alternative Phone:			
Email Address:						
Mother's Last Name:			First:		Middle Initial:	
Title: Dr. Ms. Mrs.	Name Suffix:	Age:	Is this individual the biological mother of the patient?			
Social Security Number:			Date of Birth:			
Sign attesting you are legal guardian for patient:						
Does this individual reside with patient:		Yes – Full Time	Yes – Part Time	No	Other	
Physical Address:				Martial/Legal Status:		
City:	State:	Zip Code:	If mailing address differs from physical address, please report additional information.			
Cell Phone:			Alternative Phone:			
Email Address:						

Patient Education Information:

School Name:							
School Address:							
City:		State:		Zip Code:		Grade Level:	
Does the patient have an active IEP:				If patient has an IEP, please provide a copy prior to consultation.			
Percent of Time in Mainstream Classroom:				Percent of Time in Resource Classroom:			
Name of School Personnel:				Position (i.e. Teacher, Principal, Speech Therapist):			

You may supplement this list and attach it to this packet as needed.

Treatment Information (Privatized treatments only. No treatments provided through the school system):

Name of Speech Therapist:				
Name of Speech Therapist Practice:				
Physical Address:				
City:	State:	Zip Code:		If mailing address differs from physical address, please report additional information.
Phone Number:	Email Address:			
Frequency of Treatment:	Treatment Start Date:			
Response to Treatment:				
Name of Occupational Therapist:				
Name of Occupational Therapist Practice:				
Physical Address:				
City:	State:	Zip Code:		If mailing address differs from physical address, please report additional information.
Phone Number:	Email Address:			
Frequency of Treatment:	Treatment Start Date:			
Response to Treatment:				

You may supplement this list and attach it to this packet as needed.

Contact Permission:

Form of Contact	May be contact you using this information?	May we leave a detailed message?	May we leave a non-detailed message?	Please rank the order in which we you would like to contact you (Please more a "1" for the first point of contact)
Patient Address	Yes No	Yes No	Yes No	
Father's Address	Yes No	Yes No	Yes No	
Father's Cell Phone	Yes No	Yes No	Yes No	
Father's Alt. Phone	Yes No	Yes No	Yes No	
Father's Email	Yes No	Yes No	Yes No	
Mother's Address	Yes No	Yes No	Yes No	
Mother's Cell Phone	Yes No	Yes No	Yes No	
Mother's Alt. Phone	Yes No	Yes No	Yes No	
Mother's Email	Yes No	Yes No	Yes No	

Patient/Member:____________________

Disclaimer and Signature:

Disclaimers: Therapy Center Acadiana does not discriminate on the basis of disability type or level, sex, race, creed, sexuality, nationality, gender identity, or ethnic background. Therapy Center of Acadiana holds the right to release any patient at any time due to clinical reasoning such as extreme situations that may endanger the health or safety of patients, staff, or others. It is the responsibility of the patient's legal guardians to ensure all information provided to Therapy Center of Acadiana remains updated to ensure accurate treatment. All relevant information that concerns treatment should be fully disclosed in writing and failure to disclose important information about patient behavior, medical conditions, treatment needs, or medical history shall absolve Therapy Center of Acadiana and its staff of any liability associated with unreported information. All information must be present along with supporting documents prior to receiving treatment. Your signature below attests to the fact that the provided information is accurate and up-to-date and that you agree with all of the aforementioned terms and conditions. The patient's legal guardian, signing below, gives Therapy Center of Acadiana the right to disclose your Protected Health Information with your payer source solely for the purposes of securing payments for our services. That patient's legal guardian, signing below, gives Therapy Center of Acadiana the right to disclose your Protected Health Information with your Primary Care Physician, Diagnosing Physician, Referring Physician, or any other professional entrusted with managing your medical and behavioral health services.

______________________________________ ______________________________________

Signature of Legal Guardian Date of Signature

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Printed Name of Legal Guardian