

Miracle Kids
MIRACLE KIDS LLC
1442 Dresden Drive, Unit # 258
Brookhaven GA 30319

PATIENT INFORMATION

PATIENTS'S NAME: _____ SEX M F

DATE OF BIRTH: _____

HOME ADDRESS: _____

HOME /WORK PHONE: _____ EMAIL ADDRESS: _____

PARENT/GUARDIAN: _____ RELATIONSHIP: _____

NOTIFY IN CASE OF EMERGENCY: _____

RELATIONSHIP: _____ PHONE: _____

REFERRING PHYSICIAN: _____

PRIMARY CARE PROVIDER: _____

SKILLED DIAGNOSIS: _____

*IF DUE TO AN ACCIDENT—HOW/WHEN AND WHERE DID IT HAPPEN? _____

HOW WIL YOU PAY FOR SERVICES?

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> MEDICAID | <input type="checkbox"/> BABIES CAN'T WAIT | <input type="checkbox"/> WORKER'S COMP |
| <input type="checkbox"/> GROUP INS. | <input type="checkbox"/> PRIVATE INS. | <input type="checkbox"/> LITIGATION |
| <input type="checkbox"/> PRIVATE PAY | <input type="checkbox"/> SECONDARY INS. | |

INFORMATION RELEASE

I hereby authorize the respective therapist, to release and receive medical records and other information relating to my care and my dependent's care. I understand that the information contained in medical records is confidential and will be released only upon my consent.

Signature of Parent or Guardian

Date

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INSURANCE INFORMATION/AUTHORIZATION

PATIENTS'S NAME: _____

MEDICAID #: _____

INSURANCE COMPANY NAME: _____

INSURANCE PLAN NAME: _____

INSURANCE PHONE NUMBER: (____)_____ INSURANCE FAX NUMBER: (____)_____

BILLING ADDRESS: _____

ID#: _____ Group #: _____

INSURED'S NAME: _____

INSURED'S DATE OF BIRTH: _____
(IF DIFFERENT FROM PARENTS)

ADDRESS: _____

PHONE NUMBER: (____) _____

RELATIONSHIP: _____

INSURED'S EMPLOYER: _____

STATEMENT TO PERMIT PAYMENT TO THE PROVIDER FOR OT/PT/ST

I certify that the above information given by me is correct. I the release of medical records or other information necessary to process claims. I hereby assign payment directly to respective therapist for all benefits otherwise payable to me for these services.

I understand that the medical expenses not covered by private insurance for myself or for my dependents are ultimately my responsibility.

Date

Signature of Parent or Guardian

Date

Responsible Party Signature