**phone (580) 353-8900 fax (580) 353-8903 email:**
goretherapy.center@att.net
**1001 SW A Ave. Lawton, OK 73501**
www.goretherapycenter.com
Gore-Therapy-Center on Facebook

## PATIENT INFORMATION:

| | | |
|---|---|---|
| Patient Name: | Age: | Sex: ☐ M ☐ F |
| Patient SS #: | DOB: | |
| Patient Address: | | |
| Name of Person Completing this Form/Relationship to patient: | | |
| Name of School: | Grade in School (if applicable): | |

## PARENT / LEGAL GUARDIAN INFORMATION

| | | |
|---|---|---|
| Name: | Relationship: | Cell #: |
| Address: | | |
| Employer: | | Work #: |
| SS #: | DOB: | Marital Status: |

| | | |
|---|---|---|
| Name: | Relationship: | Cell #: |
| Address: | | |
| Employer: | | Work #: |
| SS #: | DOB: | Marital Status: |

If child does not live with both parents, who has legal custody of the child? ***(Please provide copy of court order to the front desk.)***_____

**Emergency Contact (other than parent)**: Name_____ Phone # _____

**Relationship to patient:** _____

**Primary Insurance Coverage:** (Please furnish insurance card)

| | | | | | |
|---|---|---|---|---|---|
| Insurance Name: | | | | | |
| Member ID: | | Group Number: | | | |
| Sponsor Name: | SSN #: | | DOB: | | |
| Sponsor address if different than parent/legal guardian information: | | | | | |
| Patient's relationship to Sponsor: | | | | | |
| **If Tricare:** | ☐ Active | ☐ Retired | ☐ Prime | ☐ Standard | ☐ Reserve Select |

**Secondary Insurance Coverage:** (Please furnish insurance card)

| | | | | | |
|---|---|---|---|---|---|
| Insurance Name: | | | | | |
| Member ID: | | | Group Number: | | |
| Sponsor Name: | | SSN #: | | DOB: | |
| Sponsor address if different than parent/legal guardian information: | | | | | |
| Patient's relationship to Sponsor: | | | | | |
| **If Tricare:** | □ Active | □ Retired | □ Prime | □ Standard | □ Reserve Select |

**Medicaid/Soonercare Members Only:**

| | |
|---|---|
| | No, I *DO NOT* have any other Medical Insurance |
| | Yes, I *DO* have other Medical Insurance (please list above) |
| | Yes, I DO understand if I become Medicaid ineligible I will be responsible for any payments occurred during the ineligibility period. |

## PAYMENT INFORMATION:

**Financially Responsible Party:**

| | | |
|---|---|---|
| Name: | Relationship: | Cell #: |
| Address: | | |
| Employer: | | Work #: |
| SS #: | DOB: | |

***Note: When you have Commercial Insurance, Tricare, and Medicaid coverage, Medicaid is always the Secondary or Terciary insurance and all claims will need to be submitted through the primary insurance first to avoid any claim denials from Medicaid. Failure to submit through the primary insurance will result in non-payment from Medicaid and financially responsible party will be held liable for all charges due to failure to disclose other insurance coverage.***

***Insurance:*** *All policies covering the patient* ***MUST*** *be listed. Failure to disclose additional insurance coverage in a timely manner may result in a claim refiling fee and claims denial.*

## FINANCIAL STATEMENT

Payment is due immediately upon the provision of services unless a previous arrangement has been made. Total charges and/or the full amounts of co-payments/co-insurance are due at the time of service. Failure to pay the co-payment at the time of service can result in the loss of healthcare benefits and/or dismissal from GTC. Unwillingness to authorize GTC to release information for purposes of obtaining reimbursement or determining coverage may result in GTC requiring that services be paid in full on a cash basis at the time those services are rendered. Any accounts with an outstanding balance which is unpaid for 90 days or more will be required to pay the outstanding balance and any additional charges incurred at the time of service and must make arrangements for the payment of any outstanding balance turned over for collection. Any future services may be made available only on an immediate cash payment basis. GTC may, at its discretion, choose to work with those patients who incur accounts having a large dollar balance by creating a payment schedule or

other appropriate arrangement. In the event of default, the financially responsible party must pay all costs of collection incurred by GTC, including but not limited to attorney's fees. An additional 5% charge will be added to any balances exceeding 120 days. By virtue of the signature below, the signee acknowledges that he/she has read the above information and agrees to be bound by all GTC payment policies.

Financially Responsible Person Name (Print): _____

Financially Responsible Person Signature: _____

Date: _____

**ASSIGNMENT OF BENEFITS & TREATMENT AUTHORIZATION**

I hereby authorize payment of any benefits for services rendered by GTC to be made directly to GTC. I authorize GTC to refund any overpaid insurance benefits where the overpayment is subject to coordination of benefits. I also agree to remit any insurance payments made directly to me for services rendered at GTC, unless I have already paid GTC the necessary amount for the service in question.

By virtue of my signature, I authorize Gore Therapy Center (herein after refered to as GTC) and any of its employees or other authorized personnel or agents to provide therapy services to the patient.

Parent/Guardian signature _____ Date _____

**STATEMENT OF SERVICES:** (Please check **one**)

| | |
|---|---|
| | My child does not receive services from any public school, private facility or Sooner Start Early Intervention program at this time. He/She is presently receiving services only from Gore Therapy Center. |

| | | |
|---|---|---|
| | In addition to receiving services from Gore Therapy Center, my child is also receiving (Circle all that apply) | |
| □ Speech Therapy | Date of last evaluation: | Facility: |
| □ Occupational Therapy | Date of last evaluation: | Facility: |
| □ Physical Therapy | Date of last evaluation: | Facility: |
| □ Counseling Services | Date of last evaluation: | Facility: |

***I will provide a copy of my child's Individualized Education Program to Gore Therapy Center

**WEBSITE AND SOCIAL MEDIA RELEASE**

| | |
|---|---|
| | **No**, I do not wish to have my child's picture/video on the GTC Website and/or Facebook page. |
| | **Yes**, I (the undersigned) do hereby grant permission to GTC to post my and/or my child's activities, video, photo or other item, hereinafter referred to as "Materials." I understand that the "Materials" may be posted to the GTC website and/or GTC Facebook page. I hereby release to you, your representatives, employees, managers, members, officers, parent companies, subsidiaries, and directors from all claims and demands liability of any kind that may arise in connection with any use of said materials. This includes, without limitations, all claims for invasion of privacy, infringement of my right of publicity, defamation, and any other personal property rights. **I acknowledge that my child is under 18 years of age and lacks the legal capacity to enter into binding agreements.** |

## CHILD PICK-UP AUTHORIZATION

Please complete the section below ***relating to those persons who have your permission to pick up your child from therapy***. For your child's safety, we do not allow children to be picked up by a different person other than the one who has brought them in, without prior written authorization. Anyone other than the person who brings the child to the appointment may be asked for photo identification.

Other authorized persons:

| | | |
|---|---|---|
| Name: | Relationship: | PH#: |
| Name: | Relationship: | PH#: |

This authorization shall be in effect from _____ to _____ or □ until further notice.

## DESIGNEE AUTHORIZATION

The following person(s) (other than the legal guardian/s) may act on my behalf for the purpose of disclosure of medical information, providing or receiving medical records, authorizing therapy arrangements and schedule changes or any actions relating to the care and therapy provided for my child by GTC. I understand that it is my responsibility to inform GTC if my arrangements with the below mentioned responsible party changes and access to my child's information is no longer allowed.

| | | |
|---|---|---|
| Name: | Relationship: | PH#: |
| Name: | Relationship: | PH#: |

This authorization shall be in effect from _____ to _____ or □ until further notice.

## SIGNATURE

Parent/Guardian name: _____

_____ _____

Parent/Guardian signature Date