PLAY WORKS therapies, p.a.

For Holy Family Catholic School 2021-2022

Initial Contact Date: _____

Patient's Name: _____ DOB: _____

Parent's Name: _____

Address: _____

_____

Home Phone Number: _____ Mom's Cell: _____

Mom /Dad Work Number: _____ Dad's Cell: _____

Email Address: _____

Primary Care Physician: _____

Phone: _____ Fax: _____

Patient's Diagnosis or Concern: _____

Diagnosing documentation is required for Autism

Prescription required prior to treatment.

Services Requested: ☐ ST ☐ OT

Please initial beside each statement below:

_____I acknowledge that my invoices will be received via the email address I have provided above.

_____I understand that all changes to my insurance or address must be made via the website or directly to the office staff, and not to my individual provider.

Insurance Company: _____ ☐ PPO ☐ EPO ☐ HMO

Policy Holder's Name: _____ DOB: _____

Policy ID/ Group ID: _____ / _____

SSN: _____ Insurance contact number from back of card:_____

Secondary (if applicable)

Insurance Company: _____ ☐ PPO ☐ EPO ☐ HMO

Policy Holder's Name: _____ DOB: _____

Policy ID/ Group ID: _____ / _____

3663 Crown Point Court
Jacksonville, FL 32257
Ph: 904-288-8910 Fax: 904-288-8912
Email: info@playworkstherapies.com

Patient Name: _____

DOB: _____

Statement of Patient Financial Responsibility

Play Works Therapies, PA does not guarantee insurance coverage. Insurance benefits are not a guarantee of payment. Your insurance policy is a contract between you, your employer and your insurance company. All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered" or "not medically necessary" you will be responsible for the charge.

Payment, co-payment, deductibles and co-insurance are due at each visit. Cash, checks, VISA and MasterCard are the accepted forms of payment. Any returned checks are subject to a NSF fee of $25 which will be due at the next visit. Although invoices are sent, it is ultimately your responsibility to keep your child's account current. Please be aware of your benefits. You may send a check weekly with your child, call our office to make a credit card payment or, for your convenience, you may place a credit card on file for automatic billing.

Please understand that you are financially responsible for all charges whether or not they are paid by insurance.

Authorization of Treatment

I have read and understand the patient financial responsibility described above. I agree to pay, promptly and in full, any amounts due to Play Works Therapies, PA including co-payments, deductibles, and amounts for non-covered or services by my insurance company.

_____ _____

Signature: Date:

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