Welcome!!!

Thank you for choosing Access Therapy Group PLLC to meet the needs of your child. Today your child will be seen by one of our licensed Physical, Occupational and/or Speech Therapists based on the prescription that you presented to our office with from your child’s doctor. The therapist will evaluate your child and discuss with you the recommendations of treatment to achieve the goals that presented your child to our office. Initial evaluations generally run 1 hour in length with subsequent visits typically 30 minutes. Again, the plan of treatment will be discussed with you at your child’s initial assessment. Any concerns/questions that you may have please bring to the attention of your therapist.

Our office will bill your insurance company for therapy services that your child receives. Our office will contact your insurance company to confirm that your insurance carrier covers the therapy that your doctor has referred your child to this clinic for BUT it is highly recommended that you as the parent/guardian contact your insurance company to verify your own child’s coverage. All insurance policies differ on what services they cover and for how many sessions they allow. Copays are due at the time of service. If your insurance plan has a deductible, we will bill you for that after we receive notification from your carrier. On the back of your insurance card is a number that members may use to contact their own insurance company to confirm coverage. If we do not participate with your specific insurance company and you have chosen to pay privately, that fee is due at time of service.

Access Therapy does have a 24 hour cancellation policy. Contact the office at 518/280-4294 to reschedule your appointment. We ask that if your child becomes ill with vomiting, diarrhea, rashes, fevers or any other symptoms that may be contagious, please contact us as soon as possible to reschedule your appointment. We fully understand that children do become ill rather suddenly but do appreciate you contacting the office as soon as possible.

How did you hear about Access Therapy?? ________________________________

Attached you will find paperwork for you to complete prior to your child’s evaluation. Should you have any questions or require assistance filling out the packet, do not hesitate to ask. Again, we thank you for choosing Access Therapy Group PLLC to meet your child’s therapy needs.

__________________________________________  ________________________
Signature                                                                                       Date
PATIENT INFORMATION FORM

Patient Name: _______________________________________________________

Address ___________________________ City __________________ Zip _______

Home Phone ______________ Cell Phone ______________ Work Phone ________________

Social Security Number ___________________ Date of Birth ___________ Gender M or F

Referring Doctor ___________________________ Diagnosis ___________________________

Have you seen a Physical/Occupational/Speech Therapist in the past year? Yes _____ No ____

Parent/Guardian Name: ________________________________________________

Parent/Guardian DOB: _______________ Social Security Number ________________

Name of Primary Health Insurance __________________________________________

Id# _____________________________ Group ____________________________________

Name of Insured ___________________________ Relationship to patient __________

Social Security Number of Insured ___________________________ DOB of Insured _______

Name of Secondary Health Insurance _______________________________________

Id# _____________________________ Group ____________________________________

Name of Insured ___________________________ Relationship to patient __________

Social Security Number of Insured ___________________________ DOB of Insured _______

Date of Accident __________ Policy Number __________ Claim Number ________

I understand that I am financially responsible for all charges not paid by my child’s insurance company. I understand that I will pay my child’s copay or private pay fee at the time of service. I acknowledge that I have presented accurate insurance information to this clinic and agree to contact my child’s insurance company to confirm my child’s therapy benefits and my financial responsibility to Access Therapy Group, PLLC.

____________________________________________                     _______________________                     Parent/Guardian            Date