ComKey Therapy, PLLC

Because Communication is the Key
Unlock Your Potential

Service Request

_____ Speech Therapy

_____ Behavioral Therapy (CT Only)

_____ Occupational Therapy (CT Only)

Reason for Request: _____

_____

Patient Information

Patient's Last Name: _____

Patient's First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Male ____ Female ____

Guarantor's Information

Name: _____

Work Phone: _____ Cell Phone: _____

Email address: _____

Emergency Contact

Name: _____

Relationship: _____ Contact Number: _____

Medical Information

Primary Care Physician: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Office Number: _____ Fax Number: _____

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Insurance Information

Primary Insurance Carrier: _____

Policy Holder Name: _____ Male ____ Female ____

Date of Birth: _____ Social Security Number: _____

Policy Number: _____ Group Number: _____

Contact Number: _____

☐ I DO request services be placed on hold when my Insurance eligibility and/or if treatment days have been terms/lapses. I understand that no therapy will be provided during this time.

☐ I DO NOT request services be placed on hold when my Insurance eligibility and/or if treatment days have been terms/lapses. I understand that I will be responsible for all charges for services during this time and may be required to provide a deposit.

Social Media Release

To publish individual student written, artwork, photos and/or voice on social media (such as ComKey Therapy Facebook, comkeyst.com website or twitter) the client's, parent and legal guardian permission are required.

_____ Yes, I give permission for publication of my child's photo and/or voice on social media

_____ No, I give permission for publication of my child's photo and/or voice on social media

Professional Video and audio Release

I authorize ComKey Therapy to record my child in video and/or audio format for the purposes of therapy, research, education, and/or review by Comkey employees or other professionals authorized by ComKey for the direct purpose of developing treatment and/or evaluating my child's progress. At any time, I may request a copy of such video and/or audio which may only display my child (no group therapy session will be viewable by other than ComKey personal and affiliates).

Assignment of Insurance Information and Benefits

By signing this form, you have agreed to allow ComKey Therapy and authorized partners to submit claims to the indicated payers above and to allow access to Patient Health Information (PHI) only as required by each individual claim that is filed to listed payer(s) above and as allowed by Health Information Privacy Accountability Act of 1996 (HIPPA). Signing this form <u>does not guarantee</u> that the payer(s) listed above will cover any and/or all expense(s). <u>It is still the patient's or responsible party's responsibility to pay any outstanding balances.</u>

_____ Date: _____

Patient/Guardian Signature

_____

Patient/Guardian Printed Name