PATIENT NAME: _____

Playful Learning Pediatric Therapy LLC

12812 Old Glenn Highway Suite A-5
Eagle River, AK 99577
Phone: (907) 317-9349
Fax: (866) 628-8601

Patient Intake/ Billing Information

Last Name:_____ **First Name:**_____ **Middle Initial:**_____

Sex:_____ **Patient DOB:**_____/__/_____

Parent or Guardian Name:_____

Address of child:_____

City:_____ **State:**_____ **Zip:**_____ **Phone:**_____

Mailing Address:_____

City:_____ **State:**_____ **Zip:**_____

Email:_____ **Do you text?**_____

Insurance identification number: _____

Responsible billing Party:_____

Primary Insurance: Insurance holders name:_____

Insurance address:_____ **Phone:**_____

Insured (i.e. parents) DOB:_____ **SS#:**_____

Secondary Insurance: Insurance holder name:_____

Insurance address:_____ **Phone:**_____

Insured (i.e. parents) DOB:_____ **SS#:**_____

Tertiary Insurance: Insurance holder name: _____

Insurance address: _____ **Phone:** _____

Insured (i.e. parents) DOB:_____ **SS#:**_____

Emergency Contact:_____ **Phone:**_____

PATIENT NAME: _____

Release, Assignment and Statement of Responsibility

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to the provider(s). I understand that I may revoke consent at anytime in writing to this office. I further understand that I am responsible for payment for all products and services rendered to me or any patient for which I am the guarantor of payment.

Consent to Treatment

By signing below, I give my consent for examination and the performance of any tests or procedures needed. If the patient is a minor by signing I give consent for examination, tests and procedures for the above minor patient.

_____

Signature of Patient or Personal Representative: **Date:**
(Or Witness if signature is by mark)

Printed Name of Personal Representative or Witness Description of Personal Representative's Authority:

Release of Liability

I as the undersigned acting as legal guardian and or legal power of attorney, give my informed consent for child:_____, to participate in any Occupational Therapy activity that is conducted in any location, this includes transportation to and from the location, on-site and community based therapeutic activities. These activities may include but are not limited to sports, water, boats, bicycles, swings, playgrounds, climbing walls, snow, ice, all wheeled recreational items, balls, ropes and jumping from various heights, trees, and interaction with other children or persons. I am aware that there are inherent risks in participating in activities that may challenge my child and I accept and am aware of these. In the event of any physical or mental injuries sustained in any activities facilitated by Playful Learning Pediatric Therapy, LLC its business associates in contract, all employees, managers and members of Playful Learning Pediatric Therapy, LLC are released from any and all liability.

This release of liability is perpetual during the treatment time of the above participating person- beginning date of signature below.

Child name: _____ **DOB:** _____

Signature of Patient or Personal Representative: **Date:**
(Or Witness if signature is by mark)

Printed Name of Personal Representative or Witness Description of Personal Representative's Authority:

PATIENT NAME: _____

Playful Learning Pediatric Therapy LLC

Mailing Address:
12110 Business Blvd Ste A06-413
Eagle River, AK 99577
Phone: (907) 317-9349
Fax: (907) 622-7529

Notice of Privacy Practices & Your Rights

We are required by federal and state laws to maintain the privacy of your/ your child's 'Protected Health Information', PHI. Your signature below indicates you have received a copy of the 'Notice of Privacy Practices and Your Rights', which describes how health care information about you or your child may be collected, used and disclosed for purposes of treatment or payment or for other specified purposes that are permitted and required by law. This notice also details how you may access this information.

If you have any questions regarding this notice, please call us at (907) 317-9349

Child name: _____	**DOB:** _____
Signature/Title of Patient or Personal Representative: (Or Witness if signature is by mark)	**Date:**
Printed Name of Personal Representative or Witness Description of Personal Representative's Authority:	
Witness signature/Title:	**Date:**