

Therapy Links, Inc.
Integrated Therapy for Special Children
15316 Huebner Rd. suite# 202, San Antonio, TX 78248
Phone: (210) 614-4567 Fax: (210) 614-4999

Patient Name: _____ M / F Date of Birth: _____
Address: _____ SSN: _____
City: _____ State: _____ Zip: _____ Home Number: _____
Referring Physician: _____ Phone: _____ Fax: _____
Diagnosis: _____ Email: _____

Mother's
Name: _____
Address: _____
City/State/Zip: _____
SSN: _____ DOB: _____
Employer: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____

Father's
Name: _____
Address: _____
City/State/Zip: _____
SSN: _____ DOB: _____
Employer: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____

Referring Physician: _____

Insurance

Name of Primary Insurance Company: _____ Phone: _____

Name of Policy Holder: _____ DOB: _____

Policy ID #: _____ Group #: _____

Payment Policy / Release

Payment for professional services is the responsibility of the accompanying parent / guardians at the time of services being rendered. Payment is due upon check in. As a courtesy, the office will file an insurance claim for reimbursement purposes at the request of the parent / guardian. It is your personal responsibility to verify coverage under his or her policy, including any deductible provisions. If for any reason the insurance plan declines to cover a service it becomes the obligation of the parent / guardian to pay for such services. I hereby authorize this office to release my medical records to my insurance company for the purpose of filling claims. We reserve the right to sever doctor / patient relationship if these terms are not met. I have read and agree to abide by this payment for services policy.

Cancellation Policy

In order for your child to benefit most from therapy, it is important to keep absence to a minimum. We require 24 hours' notice if you must cancel an appointment. Please be advised that you may be assessed a \$25 cancellation fee for failure to notify us of cancellations (no-show). After 3 "no-shows" you may forfeit your appointment permanently. We appreciate your assistance and the opportunity to treat your child. Thank you!

Signature: _____ Date: _____