

Child's name: _____ DOB: _____

Parents name: _____

Address: _____

Telephone (day): _____

Telephone (evening): _____

Email: _____

Referred by: _____

EMERGENCY CONTACT

Name _____

Relationship to child _____

Telephone _____

ALLERGY ALERT/DIETARY RESTRICTONS

_____ hereby assert that the above
named child has the following allergies and/or food restrictions:

I am not aware of other allergies and I authorize PlayWrite Therapy to use foods, scents, and textures other than those listed above for therapeutic purposes.

Signed: _____



CONSENT FOR TREATMENT and RELEASE & EXCHANGE OF INFORMATION

I authorize and direct PlayWrite Therapy to perform appropriate assessment and treatment procedures upon the above named child. I further authorize and direct PlayWrite Therapy, having assessed and/or treated the above named child to release any appropriate information acquired in the course of the assessment and treatment to the following agencies, facilities, schools, or related professionals:

School: _____

Medical Doctor: _____

Psychologist/Educational Therapist: _____

Speech Therapist/Physical Therapist: _____

Other: _____

Insurance & Policy Number (only if you plan to seek reimbursement): _____



PAYMENT AGREEMENT

I have read and understand the attached letter stating policies of practice, including the cancellation policy. A cancellation after 8:00 AM the day of treatment will be charged at the full treatment rate. If your treatment time is before 10:00 AM, please call by 5:00 PM the previous business day to avoid being charged.

I agree to pay PlayWrite Therapy the full amount of any and all fees related to services rendered. I understand that if I am seeking reimbursement from my health insurance company, I must file a claim for benefits independently. Payment is expected upon receipt of bill. Bills that remain unpaid for 30 days will incur a late charge of 18% annually (compounded daily).

Fees are as follows:

- Assessment & report:..... \$600
- Assessment w/school visit & report: \$700
- **Treatment/Consultation: \$115/session (50 minutes)
- **Reports & Home programs:..... \$115/hour
- **Travel time:..... \$115/hour (billed in 15 min. increments)

Responsible Party Signature: _____

Relationship to Client: _____ Date: _____

How would you prefer to receive your monthly invoices:

US Mail: _____

email: _____