PLAY WORKS therapies, p.a.

School & Schedule: _____

Patient's Name: _____ DOB: _____

Parent's Name: _____

Address: _____

_____

Home Phone Number: _____ Mom's Cell: _____

Mom /Dad Work Number: _____ Dad's Cell: _____

Email Address: _____

Primary Care Physician: _____

Phone: _____ Fax: _____

Patient's Diagnosis or Concern: _____

Diagnosing documentation is required for Autism

Prescription required prior to treatment.

Services Requested: ☐ ST ☐ OT

Please initial beside each statement below:

_____I acknowledge that my invoices will be received via the email address I have provided above.

_____I understand that all changes to my insurance or address must be made via the website or directly to the office staff, and not to my individual provider.

Insurance Company: _____ ☐ PPO ☐ EPO ☐ HMO

Policy Holder's Name: _____ DOB: _____

Policy ID/ Group ID: _____ / _____

SSN: _____ Insurance contact number from back of card:_____

Secondary (if applicable)

Insurance Company: _____ ☐ PPO ☐ EPO ☐ HMO

Policy Holder's Name: _____ DOB: _____

Policy ID/ Group ID: _____ / _____

3663 Crown Point Court
Jacksonville, FL 32257
Ph: 904-288-8910 Fax: 904-288-8912
Email: info@playworkstherapies.com

CC Number: _____
Exp Date: _____
Security Code: _____
Billing Zip: _____

Patient Name: _____ DOB: _____

Patient Financial Responsibility

Play Works Therapies, PA does not guarantee insurance coverage. Insurance benefits are not a guarantee of payment. Your insurance policy is a contract between you, your employer, and your insurance company. All health plans are not the same and do not cover the same services. Please be aware of your insurance benefits. In the event your health plan determines a service to be "not covered" or "not medically necessary" you will be responsible for the charge and payment will be due within 30 days of invoice date.

Co-payment, deductibles, and co-insurance are due for each visit, and we require a credit or debit card be placed on file to cover these charges. For monthly invoiced amounts/patient responsibility, cash, check, VISA, and MasterCard are the accepted forms of payment. You may also make a payment via PayPal to info@playworkstherapies.com. Any returned checks are subject to a NSF fee of $35. Although invoices are sent monthly, it is ultimately your responsibility to keep your child's account current.

Please understand that you are financially responsible for all charges whether or not they are paid by insurance. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. If your insurance plan or company changes for any reason, please notify us immediately prior to your next date of service so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 60 days, the balance will automatically be billed to you.

Authorization of Treatment

By signing below, I acknowledge that I have read and understand the patient financial responsibility noted herein and authorize treatment for my child. Further:

1. I agree to pay promptly and in full any amounts due to Play Works Therapies, PA including co-payments, deductibles, and amounts for non-covered or services by my insurance company within 30 days of invoice date.
2. My credit card on file shall be charged for co-pays, co-insurance, and deductible amounts for services rendered that were not paid in person.

_____ _____
Signature Date

_____
Printed Name

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