7/2011

Southland Therapy Services, Inc.
Insurance Release Form
Patient Information & Therapy Authorization

Name:_____ Date of Birth_____ Age_____ Start of Care Date:_____
Address:_____ Referring Physician:_____ Phone#_____
_____ Patient's Social Security #_____
Phone:(home)_____ (work)_____ (cell)_____ (other)_____

Email address: _____

Caregivers Name (and relationship)_____

Primary Insurance Coverage Information
Payor:_____ Plan_____ Policy#_____ Group#_____

Claims address:_____ Phone:_____

Policy Holder Information:

Full Name:_____ **Relationship to patient:**_____ **DOB:**_____

Employer:_____ Gender:_____

Address and Phone # (if different than Patient)_____

Secondary Insurance Coverage Information
Payor:_____ Plan_____ Policy#_____ Group#_____

Claims address:_____ Phone:_____

Policy Holder Information:

Full Name:_____ **Relationship to patient:**_____ **DOB:**_____

Employer:_____ Gender:_____

Address and Phone # (if different than Patient)_____

CONSENT TO TREATMENT

I understand that I have been referred for therapy services and care with Southland Therapy Services. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that has been prescribed by my physician and/or recommended by my therapist. By signing this agreement, I consent to have Southland Therapy Services provide treatment and care as prescribed by my physician and/or recommended by my therapist.
I authorize Southland Therapy Services to use and / or disclose my protected health Information to physicians, payers of health care services and other health care providers to help provide appropriate treatment for my child.
I hereby authorize Southland Therapy Services to furnish my insurance company(s) any information that may be required in order to determine benefits and process claims. I authorize payment of medical benefits to Southland Therapy Services for services rendered to me. I certify by my signature that I have read the above and agree to these policies.

Patient Name:_____

Patient / Authorized Representative signature:_____ Date_____

Therapist Signature:_____ Date:_____