ASSOCIATED THERAPIES INC
1456 B MCLENDON DRIVE, DECATUR, GA-30033
PH: 404-728-9766; FAX: 404-728-9166

REFERRAL INFORMATION

DATE OF REFERRAL: _____REFERRAL SOURCE: _____ PHONE: _____

CHILD'S NAME: _____ DATE OF BIRTH: _____

DIAGNOSIS:_____ HOME PHONE: _____

PARENT'S NAME: _____ CELL PHONE: _____

ADDRESS: _____ WORK PHONE: _____

CITY: _____ GA ZIP: _____EMAIL:_____

PHYSICIAN:_____ PRACTICE: _____

ADDRESS: _____ CITY: _____GA ZIP: _____

PHYSICIAN PHONE NUMBER: _____ FAX:_____

SPEECH: EVALUATION/TREATMENT OT: EVALUATION/TREATMENT PT: EVALUATION/TREATMENT IEP/IFSP

_____ _____ _____ _____ YES NO

----------BENEFIT INFORMATION (Check all that apply and please rank order of billing: 1, 2, 3, etc) ----------

MEDICAID/PEACHCARE: _____ INSURANCE: _____ BCW: _____ PARENTS _____

----------INSURANCE INFORMATION----------

INSURANCE COMPANY:_____

ADDRESS:_____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

NAME OF INSURED:_____

INSURED'S ID/SSN: _____

INSURED'S POLICY/GROUP NUMBER: _____

INSURED'S EMPLOYER: _____

PLAN NAME: _____

FOR OFFICE USE ONLY

EFFECTIVE DATE: _____

TERM DATE: _____

BENEFITS:

_____

_____

_____

_____