THE CHILDREN'S THERAPY CENTER, INC.

Attention Parents

Upon completion of this packet,

Please mail to:

The Children's Therapy Center, Inc.

17045 El Camino real #106

Houston, TX 77058

You can fax to: 281-480-5691

OR

Email to: mwise@tctci.com

You can also call us for any questions at 281-480-5648

***When faxing or emailing, please save the original packet forms and bring them to your first appointment**

Once we have received your packet, we will then process your information and call you to go over insurance benefits and placement

Thank You

2020 Forms

THE CHILDREN'S THERAPY CENTER, INC.

Dear Parents,

Thank you for inquiring about *The Children's Therapy Center, Inc.* Enclosed you will find information about the therapies provided at our clinic, a questionnaire to be filled out regarding your child, an insurance form, cancellation policy and a brief note suggesting clothing appropriate for evaluation and to be worn during treatment.

Check out our website at www.TCTCI.com.

For the cost of evaluations and treatment please call the office. Evaluation times may vary depending on the client's needs.

Treatment sessions: Speech Therapy sessions range from 30-60 minutes. Occupational Therapy sessions range from 50-60 minutes. Both therapies can be 1-2 times weekly. Occupational Therapy can also be done as an intensive therapy. Price of therapies depends on length of time, insurance or self-pay.

We require full payment at the time of service, unless we are a network provider for your insurance company, in which case your co-payment, co-insurance and deductibles are due at time of treatment. Your insurance contract is between you and your insurance company, and you are fully responsible to us for the total amount of the fee should your insurance company fail to pay. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. We will call and verify your benefits; quoted benefits are not a guarantee of payment. The disclosure from the insurance company is that there is no guarantee of payment until the claim is filed. If we are not in network with your insurance company *The Children's Therapy Center, Inc.* is willing to file your insurance claims for a small office fee.

You will get a complimentary copy of each evaluation, if you need more copies there will be a fee.

Your insurance company may require a prescription from your physician referring your child to *The Children's Therapy Center, Inc.* for evaluation and therapy.

If you want *The Children's Therapy Center, Inc.* to file your insurance claims, bring your insurance card and the prescription from your physician with you to the evaluation.

Sincerely,

Susan A Zapf PhD, OTR/L, BCP, ATP
Dr. Susan Zapf, Ph.D., OTR, BCP, ATP
Director of Occupational Therapy

Kim Stocker, MA, CCC-SLP
Kim Stocker, M.A., CCC-SLP
Director of Speech-Language Pathology

_____
Parent/Guardian Signature Date

_____
Child's name

Revised 01/01/2020

2020 Forms

THE CHILDREN'S THERAPY CENTER, INC.

CLIENT'S NAME _____ **DATE** _____
(LAST) (FIRST) (MI)

ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

HM PH# _____ **WORK #** _____ **CELL #** _____

SEX _____ **DATE OF BIRTH** _____

PRIMARY CARE PHYSICIAN _____ **GROUP NAME** _____

PHONE # _____ **FAX #** _____

Father/Guardian's name _____ **Phone#** _____ **Preferred Contact Y/N**

Marital Status _____ **Father/Guardian's Email** _____

Mother/Guardian's name _____ **Phone #** _____ **Preferred Contact Y/N**

Marital Status _____ **Mother/Guardian's Email** _____

Emergency Contact _____ **Relationship** _____

Home # _____ **Cell#** _____

REFERRED BY _____ **PHONE#** _____

PRIMARY INSURANCE INFORMATION

POLICY HOLDER'S NAME _____ **SEX (Policy Holder)** _____

Employer (Insured) _____

DOB (Policy Holder) _____ **Relationship to insured** _____

POLICY HOLDER'S ID# _____

PRIMARY INS. CO. _____ **PHONE #** _____

GROUP # _____ **HMO** _____ **PPO** _____ **POS** _____

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO *THE CHILDREN'S THERAPY CENTER, INC.*
I AUTHORIZE MEDICAL NOTES TO BE SENT TO INSURANCE WHEN REQUESTED

_____ _____

(SIGNATURE OF PARENT/GUARDIAN) **(DATE)**

Revised 01/03/2020