Innovative Therapy Services
Pediatric Speech-Language Services

Expect the Best in Learning Social Language Skills

1090 Homestead Rd.
Santa Clara, CA 95050
Phone/(408) 241-2229
Fax/(408) 241-3165

Please complete the form and email back to ussom@pediatricspeech.com. Do not include your credit card information if emailing back, when we call to make the appointment we will collect the credit card information. If faxing the form you can include your credit card information.

Programs

Check the program you would like to your child screened for or to enroll in.

☐ **Tiny Tots/Puffins** ☐ **Penguins** ☐ **Sharks** ☐ **Lions** ☐ **Junior Tweets**

☐ **Senior Tweets**

INITIAL REGISTRATION FORM for All for 3'S SOCIAL SKILLS PROGRAM

Cost for each session $128.25

Section I: Patient Information Date_____

All for 3'S Group _____

Child's Name: _____ Prefer to be called:

Address:_____City:_____State:_____Zip_____

Phone (_____)_____ Work Phone (_____) _____ Cell Phone (_____)_____

The best time to contact parents:_____ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone

Date of Birth:_____ Social Security Number:_____

Name of School_____ City/State_____ ☐ FT ☐ PT

Whom may we thank for referring you? _____

Section II Responsible Party

Parent(s)/Legal Guardian(s):

Relationship to Patient: ☐ Parent ☐ Other

Name:_____ Relationship to Patient: _____

Address:_____

City:_____ State:_____ Zip:_____ Phone: (____)_____

Employer_____ Work Phone (____)_____ SSN#_____

Parent #2:

Name: _____

Address: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Pager: _____

Email: _____

Additional Contact Information: _____

_____

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Other Responsible Party:
Name: _____
Address: _____
Home phone: _____ Work phone: _____
Cell phone: _____ Pager: _____
Email: _____
Additional Contact Information: _____
_____

Person to contact in case of emergency_____ Phone_____
Email Address_____ Would you like to receive our e-newsletter? ☐ Yes ☐ No

Section III Insurance Information

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

Doctor's Information
Doctor's Name: _____
Doctor's Address: _____
Doctor's Office Phone: _____ Doctor's Emergency Phone: _____
Medical Insurer/Health Plan: _____ Policy #: _____
Allergies to Medications: _____
Allergies (Other): _____
If applicable, please note the conditions for which the child is currently receiving treatment:
_____
Note any other significant medical information:
_____
_____

Authorization to Bill Credit Card

Method of Payment: ____Check Credit Card_____ Cash_____

If by credit Card: Name as it appears on the credit card_____

Type of Credit card: Visa Master Discovery Other
Expiration Date:_____ _____Initial here to authorize payments for the therapy sessions

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Patient name:_____

INNOVATIVE THERAPY SERVICES All for 3'S
FINANCIAL AGREEMENT

1._____This Admission and Financial Agreement is applicable to the duration of your child's enrollment here at Innovative Therapy Services, and will be effective until the termination of your child's enrollment with Innovative Therapy Services. Should your child be enrolled in the summer program, be aware that other policies or agreements may be presented. Such policies and/or agreements maybe applicable to the All' for 3's program alone, or serve as a reminder to this existing Admissions and Financial Agreement. They do not, in any way, replace this Admission and Financial Agreement unless so specified. This agreement is binding and full fee will be charged. No make-ups are offered for cancellations.

2. _____Commercial Insurance Carriers: We bill most insurance carriers for you if proper paperwork is provided to us. Any outstanding balances, co-payments and deductibles are due prior to checking in for your appointments. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 30 days of billing, fees are due and payable in full from you.

3._____For all returned checks, we assess a $25 NSF charge, and report to the local district attorney's office checks that are not paid within 2 weeks of being returned to our office. Moreover, cancelled credit card transactions will result in 5% charge added to the transaction if it is not paid in full within 24 hours.

4._____If not paid according to terms the patient understands that our office reports to an outside collection agency. In the event that your account is turned over for collections, patient agrees to pay all additional fees accessed in the collection of the debt. These fees include collection agency fees and attorney fees.

5. _____As a shielding measure; we obtain secondary form of payment such as credit card. We may obtain your credit card information to have it on hand in the event you are delinquent in your payment. If you have not paid your bill within 60 days of billing, fees are due and payable in full from you, otherwise we will bill it to your credit card, upon seven business days . We will not bill your credit card without informing you.

6. _____All parents must initial next to the following policies to signify that they have read, understood and agreed to the above financial policy for payments of professional fees.

a. _____ I/We understand that if I/we have any questions or concerns about the Financial Agreement, that it is my/our responsibility to seek understanding so that I fully comply with all the policies.

b. _____ No person may pick up my child unless Innovative Therapy Services has the person's authorized signature on file. Signatures will be matched with the driver's license of the person picking up my child.

c. _____ I/We have read the Innovative Therapy Services handbook.

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d. _____ I/We understand that I /we will be charged the full fee if I fail to notify an absence prior to 24 hours.

e. _____ I/We understand that my child is not allowed to miss two consecutive sessions otherwise; I will be responsible for paying the full fee unless a doctor's note is provided.

f. _____ I/We understand that I/we are going to notify Innovative Therapy Services of vacation plans prior to my child's enrollment, so that an agreement can be reached between the parents and Innovative Therapy Services to hold my child's spot, otherwise I/we will be charged for the full fee.

Parent Signature:_____ Date:_____

Name (Please Print):_____