INTAKE FORM

<table>
<tr><td colspan="2">Today's date:</td><td colspan="2">RECEIVED BY (Office Use Only):</td></tr>
<tr><td colspan="4">PATIENT INFORMATION</td></tr>
<tr><td colspan="2">Patient's Name</td><td>DOB:</td><td>THERAPY TYPE REQUESTED
OT PT ST</td></tr>
<tr><td colspan="4">Diagnosis/Diagnoses:</td></tr>
<tr><td>Previous Therapy
❑ Yes ❑ No</td><td>If yes, date of discharge:</td><td colspan="2">Previous Therapy Agency:</td></tr>
<tr><td colspan="2">Parents' Names:
Phone:
Alt. Phone:</td><td colspan="2">Home Address (Street Address, City, State, Zip):
Address where therapy will take place (if different):</td></tr>
<tr><td colspan="4">Email Address:</td></tr>
<tr><td colspan="2">Physician Name:
Phone #:
Fax #:</td><td colspan="2">Scheduling needs/preferences:</td></tr>
<tr><td colspan="2">What else do you want us to know about your child and your family?</td><td colspan="2">How did you hear about us?</td></tr>
</table>

PRIMARY INSURANCE INFORMATION

Medicaid ❑ Yes ❑ No **Medicaid # (if applicable)** ______________________________

Private Insurance ❑ Yes ❑ No **Plan/Program Name** ______________________________

ID # ____________________ **Group #** __________________ **Access Phone Number:** _______________

Name of Insured: ______________________________ **Insured DOB:** __________________

Relation to Patient:

Self **Spouse** **Parent** **Other**

Summary of Coverage (if/when known):

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SECONDARY INSURANCE INFORMATION

Medicaid ❑ Yes ❑ No **Medicaid # (if applicable)** ______________________________

Private Insurance ❑ Yes ❑ No **Plan/Program Name** ______________________________

ID # ____________________ **Group #** __________________ **Access Phone Number:** _______________

Name of Insured: ______________________________ **Insured DOB:** __________________

Relation to Patient:

Self **Spouse** **Parent** **Other**

Summary of Coverage (if/when known):

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Patient or Guardian Agreement:
The information provided above is true and accurate; I understand that if I provide outdated or inaccurate information which results in an inability for Dynamic Therapy to be reimbursed by my insurance plan(s), I may be financially responsible for the full charges for services rendered.

Signature of Patient or Guardian: ____________________________________ Date __________________

******Pease send us a copy of both sides of your insurance card(s) in any way that is convenient for you (Fax, phone picture, email)***

CONTACT: FAITH RETSKY FOR ADDITIONAL INFORMATION OR QUESTIONS
214-405-7575 or faith.retsky@dynamictherapy.net