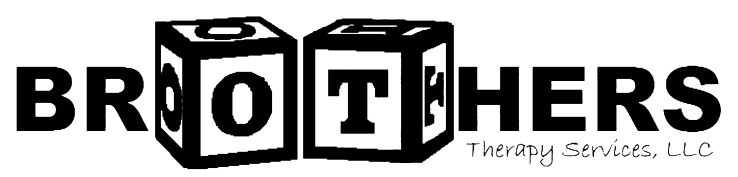


**P:** (803) 250-1403 ♦ **F:** (803) 339-1870 ♦ 208 Eascott Place, St 100, Columbia SC 29229

**Client Information Form**

|  |  |
| --- | --- |
| **Child’s Name:** ener text. | **DOB:** enter text. |
| **Parentsdf/Guardians:** enter text. |  |
| **Preferred Phone:** enter text. |  |
| **Alternate Phone:** enter text. |  |
| **Email Address:** enter text. |  |
| **In Case of Emergency** | |
| **Name:** enter text. | **Relationship:** enter text. |
| **Phone:** enter text. |  |
| **Name:** enter text. | **Relationship:** enter text. |
| **Phone:** enter text. |  |
|  |  |
| **Referring Physician:** enter text. | |
| **Contact Name and Phone number:** enter text. | |
|  |  |
| **School:** enter text. | **Address:** enter text. |
| **Grade:** enter text. | **Teacher:** enter text. |
|  |  |
| **Will anyone other than you be picking your child up? If so, who is allowed to pick your child up?**  Click here to enter text. | **Other information:**  Click here to enter text. |
|  |  |
|  |  |
|  |  |



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**Health Insurance Billing Information**

**Client’s Name:** Click here to enter text.

**Address:** Click here to enter text.

**Date of Birth:** Click here to enter text.

**Phone number:** Click here to enter text.

***\*\*Primary Insurance\*\****

**Company:** Click here to enter text.

**Benefits Phone Number:** Click here to enter text.

**Member ID:** Click here to enter text.

***\*\*Secondary Insurance\*\* (if any)***

**Company:** Click here to enter text.

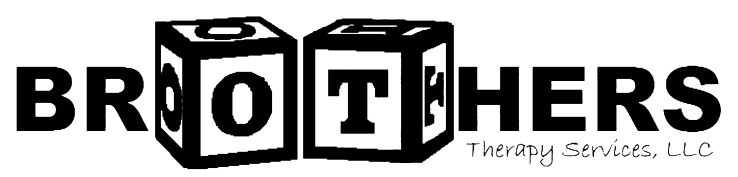
**Benefits Phone Number:** Click here to enter text.

**Member ID:** Click here to enter text.

**Physician:** Click here to enter text.

**Physician Practice Name:** Click here to enter text.

**Physician Phone Number:** Click here to enter text.



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**Therapy Release and Request for Information**

|  |
| --- |
| **Name of Child:** Click here to enter text. |
| **DOB:** Click here to enter text. |
| **Parent/Guardian(s):** Click here to enter text. |
| **Phone:** Click here to enter text. |
| **Address:** Click here to enter text. |
| **City, State, Zip Code:** Click here to enter text. |

***In order to facilitate communication while your child receives therapy, your written consent is required. Please provide the necessary information below and any updated information as needed.***

1. **Indicate your child’s primary physician, from whom a prescription for occupational therapy should be obtained**
2. **Indicate any additional physicians or professionals (other therapists, healthcare providers, tutors, teachers) to be included in your child’s treatment planning**
3. **Date and sign the form**

**I give consent to Brothers Therapy Services, LLC to release written therapy reports and/or verbal information and to obtain medical referrals for therapy, records, reports, and verbal information regarding the therapy program of my child to/from:**

**Primary physician and phone and email:**

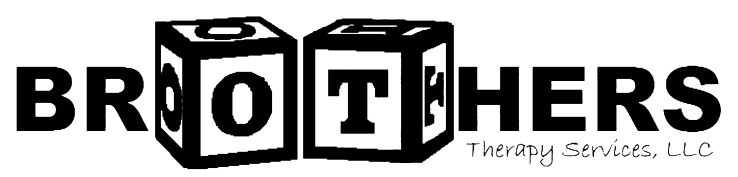
Click here to enter text.

**Additional Professionals/Providers and phone and email:**

Click here to enter text.

**This release is effective for 1 year from date this form is submitted**

|  |
| --- |
| **Parent/Guardian Signature:** Click here to enter text.  ***\*By typing your name you are hereby electronically signing and agreeing to all terms of this form.*** |
| **Date:** Click here to enter text. |



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**Media Release Form**

**I grant to Brothers Therapy Services, LLC, its representatives and employees the right to take photographs and/or videos of me and/or my child, and to copyright, use and publish the same in print and/or electronically.**

**I agree that Brothers Therapy Services, LLC may use such photographs and/or videos of me and/or my child with or without my name and for any lawful purpose, including, for example, such purposes as publicity, illustration, advertising, and Web content including social media platforms.**

**The above may take photos of me and/or my child.**

**The above may NOT take photos of me and/or my child.**

**Child’s Name:** Click here to enter text.

**DOB:** Click here to enter text.

**Signature:** Click here to enter text.

***\*By typing your name you are hereby electronically signing and agreeing to all terms of this form.***

**Today’s Date:** Click here to enter text.

**\*** Don’t forget to like us on Facebook, and check us out on the web at www.brotherstherapy.com for updates!