

ASSOCIATED THERAPIES, INC.
1244 CLAIRMONT RD., SUITE 108, DECATUR, GA 30030
PHONE: 404-728-9766; FAX 404-728-9166

REFERRAL INFORMATION

DATE OF REFERRAL: _____

REFERRAL SOURCE: _____ PHONE: _____

CHILD'S NAME: _____ **DATE OF BIRTH:** _____

DIAGNOSIS: _____

PARENT'S NAME: _____ **HOME PHONE:** _____

ADDRESS: _____ **CELL PHONE:** _____

CITY: _____ **GA ZIP:** _____ **WORK PHONE:** _____

PHYSICIAN: _____

PRACTICE: _____ **ADDRESS:** _____

CITY: _____ **GA ZIP:** _____

PHYSICIAN PHONE NUMBER: _____ **FAX:** _____

SPEECH: EVALUATION/TREATMENT **OT:** EVALUATION/TREATMENT **PT:** EVALUATION/TREATMENT

————— 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:
