



# Dumas Therapy

3203 B Vineville Avenue. Macon, Georgia 31204  
Office: (478) 737-9759 Fax (478) 475-1010

## Patient Information

Child's Name: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

### **Insurance Information** (please check one):

Medicaid     Peach Care     No insurance     Private Insurance

Medicaid #: \_\_\_\_\_

Peach Care for Kids #: \_\_\_\_\_

I authorize the release of any medical information or other documents necessary to process a claim for therapy services.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### **Consent for Treatment**

This is to certify that I \_\_\_\_\_ (parent/guardian) give my consent for \_\_\_\_\_ (patient's name) to receive therapy services. I have been given information as to the procedures and outcomes that the patient will be receiving.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### **Private Insurance Information**

Private Insurance Company: \_\_\_\_\_

Phone: \_\_\_\_\_

Claims Address: \_\_\_\_\_

Insured's ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Is there another insurance plan: \_\_\_\_\_ yes \_\_\_\_\_ no

**IF YES, COMPLETE BELOW**

Private Insurance Company: \_\_\_\_\_

Phone: \_\_\_\_\_

Claims Address: \_\_\_\_\_

Insured's ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Social Security # \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Business Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Social Security # \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Business Address: \_\_\_\_\_ Phone: \_\_\_\_\_

I certify that all information is correct. I authorize the release of any medical information necessary to process insurance claims for therapy services. I hereby assign payment for all medical benefits payable for these services directly to one of the company's names listed: Dumas Therapy, Kids-N-Action Pediatric Therapy or Massage Education Network. Also, I have read the financial policy and accept responsibility for treatment costs not covered or reimbursed by my insurance company.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Emergency Medical Release (please fill out completely)**

Parent/Guardian: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

**Contact Numbers:**

Parent/Guardian: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Caretaker: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Alternate: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

As legal guardian of the above child, I give my permission to furnish emergency medical services for minor injuries received while in a therapy session. In the event the emergency is life threatening, I give my permission to contact emergency personnel on the behalf of my child.

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date