6 Edwin Street, Morgantown, WV 26501
304-292-0173 Phone | 304-292-0174 Fax
PlayWorkscdc.com

PLAYWORKS CHILD & ADULT THERAPIES

WAIVER THERAPY REFERRAL FORMS

WAIVER AGENCY: _____

WAIVER COORDINATOR: _____ PHONE: _____

Date: _____

Last Name: _____ First Name: _____ MI: ___

Client Social Security Number: _____

Street Address: _____

City, State Zip: _____

Client Date of Birth: _____ Sex: F____ M____

TYPE OF THERAPY

___ Speech _____ Number of Units Dates Covered: _____ to _____

___ PT _____ Number of Units Dates Covered: _____ to _____

___ OT _____ Number of Units Dates Covered: _____ to _____

GAURDIAN/RESPONSILBE PARTY:

Name: _____ Telephone: _____

Street Address (if different from above): _____

City, State, Zip: _____

Additional Caregiver Name (if applicable): _____ Telephone: _____

Referring Physician: _____ Diagnosis: _____

PLEASE ATTACH A COPY OF THE PRESCRIPTION FROM REFERRING PHSYCIAN

EMERGENCY CONTACT NAME: _____

RELATIONSHIP TO CLIENT _____ PHONE _____

CONSENT FOR OCCUPATIONAL, PHYSICAL, AND/OR SPEECH THERAPY

I am entering PlayWorks Child and Adult Therapies voluntarily for the purpose of occupational, physical and/or speech therapy and do hereby consent to such treatment. I am responsible for paying for services provided to me, which may include collection fees. I authorize PlayWorks Child and Adult Therapies to release my medical records to any person or company who many need them for my continuing care, for payer review of medical services provided (utilization review) and/or for payment of my account.

_____ _____

Signature of insured/guardian Date

ASSIGNMENT AND RELEASE, GUARANTEE OF ACCOUNT

I hereby authorize and assign payment directly to PlayWorks Child and Adult Therapies for any medical benefits otherwise payable to me. I hereby authorize PlayWorks Child and Adult Therapies to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by insurance. I accept responsibility for payment of the deductible, co-payment and non-covered services.

_____ _____

Signature of insured/guardian Date

MY SIGNATURE INDICATES THAT I HAVE READ AND UNDERSTAND THE POLICIES OF PLAYWORKS CHILD AND ADULT THERAPIES AS DESCRIBED WITHIN THIS DOCUMENT.