



Connections Pediatric Therapy
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Family Contact Form

Today's Date: _____

Client Name: _____ Social Security Number: _____

Parent/Guardian responsible for payment arrangements:

Name: _____ Relationship to Child: _____

Address: _____

Home phone: _____ Cell phone: _____

Email: _____

Employer: _____ Position: _____

Work phone: _____ Social Security Number: _____

Date of Birth: _____

Primary Insurance: _____

Insurance Billing Address: _____

Insurance Contact Number: _____ Group Number: _____

Policy Number: _____ ID Number: _____

Guarantor Custodial Parent Non-custodial Parent Legal Guardian

Other Parent/Guardian in Home:

Parent: _____ Relationship to Child: _____

Address: _____

Home phone: _____ Cell phone: _____

Email: _____

Employer: _____ Position: _____

Work phone: _____ Social Security Number: _____

Guarantor Custodial Parent Non-custodial Parent Legal Guardian

We recognize that each family arrangement is unique. You may write additional comments below.

Written documentation may be required for ongoing services including applicable court orders and custody agreements. Additional Comments:

Please list others involved in the care of the child who may receive general information about services received such as appointments, schedule details, summary of session work and forms. You may specify your preference for each person or write additional comments below. Be sure to include stepparents, grandparents, caregivers, nanny, or others:

Relationship to child: _____ Name: _____

Cell phone: _____

Appointments/Schedule Session Summary Form Delivery

Relationship to child: _____ Name: _____

Cell phone: _____

Appointments/Schedule Session Summary Form Delivery Others involved in the care

Additional Comments: _____

I acknowledge that the information provided above is necessary to receive services. The information I have provided is accurate to the best of my knowledge. I hereby authorize the use or disclosure of my child's individually identifiable health information to those included on this form. I agree to provide additional information about divorce, separation and custodial agreements or other legal documents. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulation.

Name:

Relationship to client

Signature

Date