WELCOME TO:

Office Use Only

Diagnosis: _____

The Therapy SPOT for Pediatric & Adult
Speech Physical Occupational Therapy, PLLC
1383 veterans Memorial Highway- Suite 36
Hauppauge, NY 11788
(631)582-0088

Thank you for choosing our office.
In order to serve you properly we will need the following information. All information will be strictly confidential.

Patient's Name:	**Circle:** M F	**Birthdate:**	**Martial Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced
Address:	**City**	**State Zip**	**Home Phone:**
If child, parent's or guardian's name:	**Occupation:**	**Business Phone:**	**Cell Phone:**
Do you have medical insurance? ☐ Yes ☐ No	**If no, how do you intend to pay?** ☐ Check ☐ Cash ☐ Credit Card	**Primary Insurance Company:**	
Subscriber Name:	**Insured's Birthdate:**	**Policy Number:**	
Secondary Insurance Company/Subscriber Name/Policy Number:			
Person Financially Responsible for this account:		**Relationship to Patient:**	
Whom may we thank for referring you?			

REQUEST FOR RELEASE OF INFORMATION:

I authorize The Therapy SPOT, PLLC to

☐ send report(s)/medical information to the professionals as listed below.

☐ allow communication between The Therapy SPOT, PLLC and the professionals as listed below.

Please include phone number and/or mailing address:

_____

_____

_____

Patient, Parent, or Guardian Signature: **Date:**