



2150 La Dawn Lane
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PATIENT INFORMATION

Referral Source _____	Date of Referral _____
Child's Name _____	Date of Birth _____
Caregiver's Name _____	
Address _____	
Phone Number (H) _____	(W) _____ (C) _____
Email/Alternate Contact Info _____	
Diagnosis _____	
Diagnosis Code(s) 1) _____	2) _____ 3) _____
Referring Physician _____	GBHC # _____
Physician Address _____	
Physician Phone _____	Physician Fax _____

BILLING INFORMATION

Insurance Company _____	Eff/Term Date _____
Claims Address _____	
Phone Number _____	Fax Number _____
Sub ID _____	Guarantor _____
Guarantor ID _____	
Policy/Group Number _____	
Guarantor Employer _____	
Insurance Plan Name _____	
Benefits: Deductible _____ % _____	Maximums (\$/visits) _____
Medicaid/Peachcare Number _____	
Babies Can't Wait: County _____	Cost Participation _____

****Please provide a copy (front and back) of Medicaid and/or Insurance cards. Thank You!****