

Handprints and Footsteps Pediatric Therapy, LLC

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INFORMATION FOR THERAPY SERVICES

Child's Name:_____ **Child's DOB:** _____

Parent Name: _____

Address: _____

Telephone: Home: _____ **Work:** _____ **Cell:** _____

Email address: _____

Best #/Time to call: _____

Site of Service (home, daycare, etc.):

Concerns/Reason for Referral:

Insurance type: NC Medicaid	BCBS	Other:
Policy/ID #:	Group #:	
Insurance Address/Phone Number:		
Physician Information		
Dr. Name:		
Practice:		
Address:		
Phone #:		
Facility NPI #:		