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| LOGO2.png **Office: (770) 904-6419**  **Fax: (770) 904-6418**  **Peach State Pediatric Therapy**  **4992 Bristol Industrial Way**  **Buford, GA 30518** | | | | | | | | | | |
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|  | | |  |  | | | | | M | F |
| Child’s Name | | |  | Date of Birth | | | | | Sex | |
|  | | |  |  | | | | | | |
| Parent’s/Guardian’s Name | | |  | Parent’s/Guardian’s Name | | | | | | |
|  |  |  |  |  | | |  |  | | |
| Home Phone |  | Work Phone |  | Home Phone | | |  | Work Phone | | |
|  | | |  |  | | | | | | |
| Address | | |  | Address | | | | | | |
|  | | |  |  | | | | | | |
| City, ST ZIP Code | | |  | City, ST ZIP Code | | | | | | |
|  | | |  |  | | | | | | |
| Alternative Emergency Contacts | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | |  |  | | | | | | |
| Primary Emergency Contact | | |  | Secondary Emergency Contact | | | | | | |
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| City, ST ZIP Code | | |  | City, ST ZIP Code | | | | | | |
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| Medical Waiver | | | | | | | | | | |
| I hereby authorize Peach State Pediatric Therapy, Inc. to perform an initial pre evaluation of my child’s need for occupational, physical, and or speech therapy.  I am aware and consent to the following:    1. This procedure is for evaluation purposes only and does not stand as an official diagnosis.    2. Further treatment may be subject to patient obtaining an official diagnosis and prescription from his or  her primary care physician.    3. This is a onetime complimentary consultation. For further treatment an official evaluation is required and  will be billed directly to the patient and or their insurance provider. | | | | | | | | | | |
|  | | | | |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Parent’s/Guardian’s Printed Name | | | | |  | Date | | | | |
|  | | | | |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Parent’s/Guardian’s Signature | | | | |  | Date | | | | |