Early Intervention Services Registration Form

Child's Last Name _____ First Name _____MI_____

Date of Birth_____ Gender_____ Race_____

Does your Child Have Medicaid? _____If yes, Medicaid Provider _____ Medicaid Number_____

Does your Child Have Insurance?_____If yes, Insurance Provider_____ Policy Number_____

Name of Insurance Policy Holder_____ Relationship to Child_____

Primary Care Physician_____

Address_____ Phone_____

Specialists (if any)_____

_____

Other agencies/providers that work with your child (if any)_____

_____

_____

Child's Name _____ Date of Birth _____

CONSENT FOR SERVICES

The undersigned, as parent or guardian of the above-named child hereby fully consent to early intervention services provided by New Heights of Northeast Florida, Inc. in accordance with the services described in the Individualized Family Support Plan (IFSP).

AUTHORIZATION TO DISCLOSE AND EXCHANGE PROTECETED HEALTH INFORMATION

I authorize New Heights of Northeast Florida, Inc. to disclose and exchange my child's medical, developmental, educational, and other pertinent information (collectively referred to as "Protected Health Information") with Northeastern Early Steps, my child's primary care physician, and other IFSP Team members for the purpose of being provided early intervention services.

I understand that I have the right to revoke this authorization at any time and, that if I do, I must do in writing to the New Heights of Northeast Florida CEO.

This authorization shall remain active until my child's discharge from New Heights of Northeast Florida early intervention program or until I revoke it in writing.

RELEASE OF INFORMATION FOR INSURANCE CLAIMS

The undersigned, as parent or guardian of the above-named child authorize the release of any medical, developmental, or educational information necessary to process insurance claims, including Medicaid. I also authorize payment of benefits directly to New Heights of Northeast Florida, Inc. and/or Therapy Source, LLC

_____ _____

Signature of Parent or Guardian Date

_____ _____

Witness Date

ACKNOWLDEGEMENT OF RECEIPT OF EARLY INTERVENTION & THERAPY FAMILY HANDBOOK

Child's Name _____ Date of Birth _____

The undersigned, as parent or guardian of the above-named child confirm that I have received the Early Intervention and Therapy Family Handbook and agree to abide to the required policies & procedures.

_____ _____
Signature of parent or guardian Date

_____ _____
Witness Date

ACKNOWLDEGEMENT OF RECEIPT OF PRIVACY PRACTICES

The undersigned, as parent or guardian of the above-named child confirm I have been given an opportunity to review the New Heights' Notice of Privacy Practices and have received a copy of such if I chose.

_____ _____
Signature of parent or guardian Date

_____ _____
Witness Date