



# Sumlar Therapy Services, Inc.

Pediatric Physical Therapy, Occupational Therapy, and Speech Therapy  
With Hippotherapy and Aquatic Therapy

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## New Therapy Referral

Name of School

Name:	
DOB:	Diagnosis if known:
Parents'/Guardian's Name & Address: _____	
Phone Number(s) (home / cell / work) :	
Physician:	Physician's phone #:

### All Parents Please Sign:

**Authorization for Treatment:** The undersigned hereby authorizes Sumlar Therapy Services, Inc., (referred to as "Provider") to render to the patient physical therapy, occupational therapy, and/or speech therapy that the Provider and/or patient's physician determine to be necessary and advisable.

**Release of Information:** The undersigned hereby certifies that all information provided to the Provider by the undersigned is true and accurate in all respects; authorizes Provider to disclose any information, medical or non-medical, furnished to or obtained by Provider in connection with patient's diagnosis and/or treatment to any physician, government agency, (including the U.S. Department of Health and Human Services, or any of its intermediaries or carriers), insurance company or health care provider requesting such information; agrees to allow Provider access to patient medical records and agrees to allow Provider to make copies of such records; consents to the discussing by Provider of the patient's medical condition with patient's family members for medical or claims management purposes.

**Signed:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Is the student covered by Medicaid **only**?  Yes  No  
(Student has no other insurance coverage besides Medicaid)

**Medicaid**

If yes, please provide Medicaid number: \_\_\_\_\_

If yes, what is date of last Medicaid screening? \_\_\_\_\_

**ONLY**

**For Medicaid patients only:** The undersigned hereby assign and transfer to Provider the right to Medicaid payments to which the undersigned may be or become entitled to for services rendered by the Provider. The undersigned hereby authorizes Provider to apply and file for all such benefit payments on behalf of the patient and direct that such payments may be made directly to the Provider.

**Signed:** \_\_\_\_\_

**Date:** \_\_\_\_\_

### ***School representative making referral:***

Name of Representative: \_\_\_\_\_

Date of Referral: \_\_\_\_\_

Check One  Physical Therapy  Occupational Therapy  Speech Therapy

**Your Checklist:** A complete referral **must** include this form and the following:

- If student does **not** have Medicaid, a prescription for **PT, OT** or **ST** must be written by physician in traditional format
- If **Medicaid**, prescription for **PT, OT** or **ST** must be on a Medicaid Referral Form with **Sumlar Therapy** as provider
- If **homebound** or **daycare**, please provide **directions** here: