Sumlar Therapy Services, Inc.

….helping, healing, loving, and believing

193 Sam Lisenby Road
Ozark, AL 36360
Phone (334) 445-6336
Fax (334) 445-6363
email@sumlartherapy.com
www.sumlartherapy.com

For office use only INITIAL CODE:
DATE REC'D: ☐ CODE ALERT

NEW SCHOOL THERAPY REFERRAL

To be completed by SCHOOL:

Today's Date _____

Name of School _____ **School System** _____

School Representative Name_____ **Signature** _____

IEP Holder Name_____ **Email** _____

Select one or more disciplines:

☐ **Physical Therapy** ☐ **Occupational Therapy** **Speech Therapy:**

☐ **Articulation** ☐ **Stuttering**

*****Please note: A prescription or Medicaid referral is *NOT* required.***** ☐ **Language** ☐ **Other**

☐ **Information below is being completed by an authorized school representative in the instance of a contract referral where an agreement exists between Sumlar Therapy Services, Inc. and the school system making multiple referrals. By signing above the school representative is agreeing to the Authorization for Evaluation and Provision of Services.**

To be completed by PARENT/GUARDIAN:

STUDENT Name: _____ **DOB**: _____

☐ **Male** ☐ **Female** Diagnosis: _____

Parent/Guardian Name(s): _____

Home Street Address: _____

City, State, Zip: _____

Phone Number(s): _____

Email: _____

Pediatrician's Name: _____ Phone: _____

Parent/Legal Guardian Signature Required:

Authorization for Evaluation and Provision of Services: The undersigned hereby authorizes Sumlar Therapy Services, Inc., (referred to as "Provider") to render to the student physical therapy, occupational therapy, and/or speech therapy as indicated by this school system referral and to provide per the recommendations as put forth by the IEP team. **Release of Information**: The undersigned hereby certifies that all information provided to the Provider by the undersigned is true and accurate in in all respects; authorizes Provider to disclose any information, medical or non-medical, furnished to or obtained by Provider in connection with student'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 student's medical condition with student's family members and/or school representatives.

Parent/Legal Guardian SIGNATURE: _____ **Date:** _____

☐ Parent has provided verbal consent authorizing school representative to sign this form secondary to COVID-19 pandemic. Form has been reviewed with parent/legal guardian in its' entirety, including Authorization for Evaluation and Provision of Services, and Release of Information.