KidSense Therapy Group

209 Cherry Street
Milford, CT 06460
(203)874-5437 (KIDS)

PATIENT INFORMATION & INSURANCE FORM

____
Date

Patient Last Name _____________________________ First _________________ Middle Initial ___

Date of Birth _____ / _____/ _____ SSN#_____/_____/_____ Male Female

Parent's Name ________________________________ E-mail address___________________________

Address __________________________ City_________________ State_____________ Zip_______

Home # (______) _______-______ Work # (____) _______-________ Cell # (____)_______-______

Physician Information:

Name of Pediatrician or PCP: _________________________________Phone # (____) ______ - _______
(first) (last)

Responsible Party:

Person responsible for this account _________________________Relationship to patient_____________

Address_______________________________ City_____________ State_________ Zip___________

Home # (______) _______-______ Work # (____) ______-________ Cell # (____)_______-_____

Primary Insurance Information:

Name of Insured ___________________________Relationship to patient _________________________

Insurance Company ________________________ ID # ______________________ Group #__________

Secondary Insurance Information: **Do you have any additional insurance**? **Yes No**
If yes, please complete the following:

Secondary Insurance Company ________________________ID # _______________ Group #_____________

Release of Information:
I authorize release of any information concerning my child's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also herby authorize payment of insurance benefits otherwise payable to me directly to KidSense. I acknowledge and accept responsibility for any financial obligations that the insurance company does not ultimately cover.

Signature of parent: _______________________________ Date: ___________________

===

For Office Use Only: Please do not complete this section: _______________________ _________________
Customer Svs. Representative's Name Date called to verity benefits

Insurance Plan Name: ___________________________________ Effective Date_________________

Co-pay Amount $_______________ Deductible Individual $ ______________ Family $________________
OOP Max Individual $ _______________ Family $________________

Total Number of Visits _____________ ☐Calendar year ☐Plan Year Visits Used to Date: ___________
Visits combined with (PT OT ST Chiro Cardiac Pulmonary Cognitive All Therapies)

Referral required? ☐Yes ☐No Authorization required? ☐Yes ☐No Claims submitted to Orthonet? ☐Yes ☐No