KIDSENSE THERAPY GROUP
INSURANCE FORM

INSTRUCTIONS: PLEASE COMPLETE AND RETURN THIS FORM PRIOR TO YOUR FIRST VISIT.

Client's Last Name_____ First Name _____ Middle Initial _____

D.O.B (MM/DD/YYYY) _____ ☐ Male ☐ Female ☐ Non-binary

Address _____ City _____ State_____ Zip _____

Main Phone #: _____ Alternative Phone # _____

PHYSICIAN INFORMATION

Name of Pediatrician or PCP _____ Phone # _____

(first) (last)

PRIMARY POLICY HOLDER INFORMATION

Insurance Company _____ Client's ID # _____ Group # _____

Primary Member Name_____ Primary Member D.O.B _____

☐ Address Same as Client Relationship to Client_____

Address _____ City _____ State_____ Zip _____

Primary Phone # : _____

SECONDARY POLICY HOLDER INFORMATION

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

Insurance Company _____ Client's ID # _____ Group # _____

Primary Member Name_____ Primary Member D.O.B _____

☐ Address Same as Client Relationship to Client _____

Address _____ City _____ State_____ Zip _____

Primary Phone # : _____

RELEASE OF INFORMATION

I authorize release of any information concerning my/ 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 Responsible Party: _____Date: _____