Client Information/Consent to Evaluate and Treat/ Insurance Agreement

Name:_______________________________ DOB____________________________

Address:____

Parents: ____

Phone Number: ____

Insurance Name: ______________________ Policy #__________________________

Secondary Insurance:____

Physician: ____

Physician phone:_______________________ fax:______________________________

Interested in (circle) OT PT Dev. Ther.

Scheduling preference: ____

Sign/ Initial:

I, _________________________, give permission for my child, ______________________ to receive an Occupational Therapy/Physical Therapy evaluation and treatment as deemed necessary from Kid Sense Therapy. I understand that this information will be used to support a developmentally appropriate goal plan for my child and will not be shared with other agencies without my prior consent. I understand that all information gathered during evaluation and treatment will be shared with me.

_____The insurance information on record for my child is current and accurate. I consent for Kid Sense Therapy to bill the private insurance and/or Medicaid on record for all services. I authorize the release of medical information necessary to process the insurance claim.

_____I understand it is the insurance policy holder's responsibility to be familiar with their insurance benefits and assume responsibility for payment of services not paid by insurance.