TherapyWorks 4 Kids, LLC™

Insurance Information

Patient:

(Legal Name)Last_____First_____MI _____ D.O.B. _____

Primary Insurance Information: (please bring all insurance cards at time of visit)

Insured's Name (who has policy) _____Insured's D.O.B _____

Insurance Company Name_____ Insurance ph # (on back of card) _____

Provider ID# _____ Group # _____

Secondary Insurance Information: (please bring all insurance cards at time of visit)

Insured's Name (who has policy) _____Insured's D.O.B _____

Insurance Company Name_____ Insurance ph # (on back of card) _____

Provider ID number _____ Group # _____

Tertiary Insurance Information: (please bring all insurance cards at time of visit)

Insured's Name (who has policy) _____Insured's D.O.B _____

Insurance Company Name_____ Insurance ph # (on back of card) _____

Provider ID number _____ Group # _____

_____**(initial) I AUTHORIZE THAT I HAVE LISTED ALL INSURANCE COMPANIES. I WILL UPDATE THERAPYWORKS 4 KIDS WHEN I HAVE AN INSURANCE CHANGE. I WILL BE RESPONSIBLE FOR ANY CLAIMS NOT PAID DUE TO INCORRECT INSURANCE INFORMATION. ANY CLAIMS THAT NEED TO BE RE-FILED OR APPEALED DUE TO INCORRECT INSURANCE INFORMATION WILL BE CHARGED A CLERICAL FEE OF $10 PER CLAIM.**

_____**(initial) I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO: TherapyWorks 4 Kids, LLC.**

_____ Parent/Guardian Printed Name

_____ Signature

_____ Date