Family First Speech THERAPY, L.L.C.

KidsConnect Occupational Therapy, L.L.C.

NEW CLIENT INTAKE APPLICATION

(Please print clearly)

1. SERVICE & LOCATION INQUIRED

☐ Speech Therapy ☐ Occupational Therapy ☐ Both

2. THERAPY WILL BE COVERED BY

☐ Private pay *(skip sections 5 & 6 below)* ☐ Insurance *(if use insurance, WE REQUIRE 1) A PHYSICIAN'S SCRIPT/REFERRAL and 2) FRONT & BACK COPIES OF INSURANCE I.D. CARD)*

3. PATIENT INFORMATION

Last Name:______________________ First Name:______________________ Middle Name:______________________

Date of Birth:______________________ Gender: ☐ Male ☐ Female Home Phone: ______________________

Home Address:______________________ City: ______________________ State:______ Zip Code:__________

Patient's Diagnosis *(prescribed by physician)*:______________________

Mother's Name:______________________ May we disclose your child's treatment information to this person? ☐Yes ☐No
May this person receives the coverage & benefits information? ☐Yes ☐No
May we email you the coverage & benefits information after verification? ☐Yes ☐No

Mother's Email (required):______________________

Cell Phone #: ______________________ Work Phone #: ______________________ Other Phone #: ______________________

Father's Name: ______________________ May we disclose your child's treatment information to this person? ☐Yes ☐No
May this person receives the coverage & benefits information? ☐Yes ☐No
May we email you the coverage & benefits information after verification? ☐Yes ☐No

Father's Email (required):______________________

Cell Phone #: ______________________ Work Phone #: ______________________ Other Phone #: ______________________

4. EMERGENCY CONTACT *(must be different than parents listed above)*

1. Name:______________________ Phone #:______________________ Relationship to Patient:______________

5. PRIMARY INSURANCE INFORMATION

Insurance Company: ______________________ Ins. Phone # (Provider line): ______________________

Policyholder's Name:______________________ DOB:____________ SSN:______________________ Relationship to Patient: ____________

Policyholder's Home Address: ______________________ Phone #: ______________________

Policy / Medicaid I.D. #:______________________ Group #: ______________________

Policyholder's Employer Name *(if applicable)*:______________________

6. SECONDARY INSURANCE INFORMATION *(if applicable)*

Insurance Company: ______________________ Ins. Phone # (Provider line): ______________________

Policyholder's Name:______________________ DOB:____________ SSN:______________________ Relationship to Patient: ____________

Policyholder's Home Address: ______________________ Phone #: ______________________

Policy / Medicaid I.D. #:______________________ Group #: ______________________

Policyholder's Employer Name *(if applicable)*:______________________

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7. REFERRING / PRIMARY CARE PHYSICIAN

Primary Care Physician's Name:__________ Phone #: __________ Fax #:__________

Address:__________

Referring Physician's Name:__________ Phone #: __________ Fax #:__________

Address:__________

8. ACKNOWLEDGEMENT

This is a statement of our financial policy. You understand that you are obligated to ensure that our fees are paid in full. We will verify your coverage and bill your insurance carrier on your behalf when using insurance. However, you are ultimately responsible for payment of your bill.

You agree that you will pay any applicable deductible, co-payment, and/or co-insurance as determined by your insurance plan(s). Those payments will be due at the time of service. Many insurance companies have additional requirements or stipulations that may affect your coverage. You are responsible for any amounts not covered or payable by your insurance. If your insurance denies any part of your claim, you agree to be responsible to pay the full balance.

__________ __________

Patient/Guardian – Print Name Date:

__________ __________

Patient/Guardian – Signature Date: