Kids Therapy, Ltd.

www.kidstherapyonline.com

1860 W. Winchester Road, Suite 108
Libertyville, IL 60048
Phone: (847) 573-9486
Fax: (847) 549-6139

22285 Pepper Road, Suite 301
Lake Barrington, IL 60010
Phone: (847) 842-0597
Fax: (847) 842-9882

Date:____________

Child's Name: ____

Child's Date of Birth:_____________________Male___________Female____________

Address : ____

City/State/Zip____

Home Phone#: ________________________Email:______________________________

Mother's Name:_________________________Date of Birth:_______________________

Mother's Employer:____

Mother's Employer Phone Number:____

Mother's Cell Phone Number:____

Father's Name:__________________________Date of Birth:______________________

Father's Employer____

Father's Employer Phone Number:____

Father's Cell Phone Number:____

Siblings Names and Ages:____

Emergency contact person name/phone:____

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Name of Insurance Company:____

Name Of Policy Holder:_____________________________Date of Birth:___________

SS# of Policy Holder:____

Health Ins Identification Number:____________________Group Number:____________

Responsibility For Payment:

We are pleased to provide services to your child. As a courtesy to you, we will bill your insurance company for any services provided to your child at Kids Therapy. We allow 45 days from the date of service for insurance companies to pay their portion of the claim. Your help in seeing that the claims are paid within that time frame is appreciated. If a claim is delayed because of lack of information to be provided by you to the insurance company, the claim will immediately become your responsibility. Insurance claims that are denied, rejected or not paid in full within 45 days of the date of service will immediately become your responsibility. You will receive a monthly statement for amounts that become your responsibility and unpaid charges will accrue interest at a rate of 1.5% per month. If your account is turned over to an attorney for collection you will be responsible for attorney fees incurred by Kids Therapy, Ltd.

Please sign this form below to indicate your acceptance of those terms and return it to your therapist

Signature:____________________________________Date:_____________________

Patient's Name:____

Please sign below to authorize payment of medical insurance benefits directly to Kids Therapy, Ltd.

Signature:____________________________________Date:______________________

Referral/Diagnosis
Reason for this referral: ____
____
Referred by: ____
____
Does you child have a primary diagnosis? If yes, please list the primary diagnosis and any other diagnoses he/she may have: ______________________________________
____

Primary Care Physician
Primary Care Physician's Name:____
Address: ____
City: ______________________________ State/Zip Code: _____________________
Phone Number:______________________ Fax Number: _______________________

Additional Physician/Professional
Name:____
Address: ____
City: _____________________________ State/Zip Code: _____________________
Phone Number: _____________________ Fax Number: _______________________

Additional Physician/Professional
Name: ____
Address: ____
City: _____________________________ State/Zip Code: ______________________
Phone Number:_____________________ Fax Number:_________________________

Please List any professionals that you would like us to send reports to:______________
____
____
____