My Pediatric OT Services

Helping kids help themselves

New Patient Information

Date: _____ Referred By: _____

Child's Name: _____
Date of Birth: _____ Age: _____
Child's Home Address: _____
City/State/Zip: _____ Home Phone: _____
Parents/Guardian Names: _____
With whom does the Child Reside? _____
Child's siblings(Names/Ages): _____
_____

Parent/Guardian Contact Information

Parents' Email address: _____
Parents' Work Phone: Mom/Dad: _____ Mom/Dad: _____
Parents' Cell Phone: Mom/Dad: _____ Mom/Dad: _____

Emergency Contact

Emergency Contact: _____ Phone: _____
Relationship to child: _____

Pediatrician

Primary Care Physician: _____
Address: _____
City/State/Zip: _____ Phone: _____

What is your primary concern related to having your child evaluated? _____
_____
_____

How did you hear about our therapy services? _____
_____

1776 Washington Street, Walpole, MA 02081
(508) 208-8438 www.mypediatricOTservices.com

Insurance and Payment Information

Primary Insurance:

Policy #: _____

Group #: _____

Insurance Holder: _____

Relationship to Child: _____ Date of Birth: _____

Secondary Insurance:

Policy #: _____

Group #: _____

Insurance Holder: _____

Relationship to Child: _____ Date of Birth: _____

- ☐ I have called my insurance company and confirmed that **I do/do not** need a referral.
- ☐ I have called my insurance company and confirmed that **I do/do not** need prior authorization.
- ☐ I have called my insurance company and confirmed that I have _____ deductible.
- ☐ I have confirmed that my occupational therapy copayment is _____
- ☐ I have confirmed that my plan benefit includes _____ (number) OT sessions per year.

Other Payment Sources:

Alternative Address for Statements: _____

City/State/Zip: _____ Relation to Child: _____

Assignment of Insurance Benefits

I authorize direct payment of medical benefits to the above named therapist. The benefits referred to herein would be payable to me if I did not make assignment and include major medical insurance. I understand that I am personally responsible for charges not covered or paid by this assignment.

Parent/Guardian Signature: _____ Date: _____

IMPORTANT:

- **Please make sure we receive a copy of your insurance card and/or ID upon arrival at your first visit. This therapist will file claims with up to two insurances on your behalf; you will be responsible for filing any additional claims.**
- **You are responsible for verification of your insurance coverage before your initial evaluation and attaining a referral as needed. This is not a guarantee of benefits.**
- **Any co-payment is due at each visit.**