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? _____
_____

My Pediatric OT Services

Helping kids help themselves

Insurance and Payment Information UPDATED as of 1/1/2024

Primary Insurance: *(BCBS, United health, UMR, HPHC, Tufts, MGBH, Unicare)*

_____

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.

(My Pediatric OT Services NPI # is 1669753547 and needs to be provided to child's PCP for referral)

☐ I have called my insurance company and confirmed that I have a _____ deductible.

☐ I have confirmed that my occupational therapy copayment is _____.

_____

IMPORTANT:

- **Please make sure we receive a copy of your insurance card and/or ID upon arrival at your first visit.**
- **You are responsible for verification of your insurance coverage before your initial evaluation and attaining a referral as needed. It is your responsibility to notify us of any changes.**
- **Any co-payment is due at each visit. Plans in deductible will be charged $70 at each visit.**
- **Out of network plans will be charged $155 per session.**
- **Superbill can be supplied upon request for out of network plans or for submission to secondary insurance plans. We only bill primary insurance company.**

Assignment of Insurance Benefits – In-network plans.

I authorize direct payment of medical benefits to the above named provider. 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. This is not a guarantee of benefit.

Circumstances requiring payment from insured's guardian is due at time of visit as noted in above bullets under "important" header.

My signature states I have read this form in its entirety.

Parent/Guardian Signature: _____ Date: _____

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