

# Kid at Heart Therapy

## Patient Intake Information

Today's Date \_\_\_\_\_

**Patient's Name** \_\_\_\_\_ Sex \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Parent/Guardian Name(s) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email address \_\_\_\_\_

Referring Physician \_\_\_\_\_ Primary Care Physician (if different) \_\_\_\_\_

**Primary Insurance** \_\_\_\_\_

Contract Number \_\_\_\_\_ Group Number \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_

Policy Holder's Birth Date \_\_\_\_\_ Policy Holder's SS Number \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_ Work Phone Number \_\_\_\_\_

**Secondary Insurance (if applicable)** \_\_\_\_\_

Contract Number \_\_\_\_\_ Group Number \_\_\_\_\_

How did you hear about Kid At Heart Therapy? \_\_\_\_\_

### PLEASE READ THE FOLLOWING:

- I have read and completed the above questions to the best of my knowledge. I will notify Kid At Heart Therapy of any changes in my personal and/or health information.
- I understand and agree that, regardless of my insurance status, I am financially responsible for the balance of my account for any professional services rendered.
- I assign directly to Kid At Heart Therapy all benefits, if any, otherwise payable to me for services rendered.
- I authorize Kid At Heart Therapy to release all information necessary to secure the payment of benefits. I authorize use of this signature on all my insurance submissions whether manual or electronic.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date