

The Center for Pediatric Therapies, Inc.

Patient Information and Insurance Verification

Today's Date: _____

Patient Name: _____ Chart #: _____

Patient's Address: _____

City: _____ State: _____ Zip Code: _____ Home Phone: _____

Date of Birth: _____ Sex: _____

Parent/Legal Guardian Information

Father: _____ Social Security Number: _____

Father's Employer: _____ Phone #: _____

Mother: _____ Social Security Number: _____

Mother's Employer: _____ Phone #: _____

Insurance Information

Policyholder: _____

Insurance Co. Name: _____

Mailing Address for Claims: _____

City: _____ State: _____ Zip Code: _____ Phone #: _____

ID#: _____ (include prefix) Group #: _____

Effective: _____ Deductible: _____ Reached? _____

Limits? _____ Does it combine OT, PT, and ST? _____

Out of Pocket: _____ Reached: _____ Copay? _____

Coverage: _____ Any Preauth Required: _____

Spoke With: _____ Special Instructions: _____

*Referring Physician/Phone #: _____

Diagnosis: _____

*IF EARLY INTERVENTION, PLEASE LIST ANY INFORMATION WE MAY NEED FOR BILLING INSURANCE AND PATIENTS.