HAND IN HAND THERAPY

Guiding little hands. Growing big skills.

Name: _____ DOB:_____
Guardian Name: _____ DOB:_____
Relationship to client:_____
Phone #:_____ Email:_____
Address:_____

Primary Insurance Payer:_____ Insurance ID #:_____
Group #:_____ Group name:_____
Guarantor name, DOB, & SSN:_____
Address:_____
Phone #:_____

Secondary Insurance Payer:_____ Insurance ID #:_____
Group #:_____ Group name:_____
Guarantor name, DOB, & SSN:_____
Address:_____
Phone #:_____

To the best of my knowledge, the above information is accurate. I give Hand in Hand Therapy, PLLC the right to bill services as rendered.

_____ _____
Client / Legal Guardian Printed Name Relationship to Client

_____ _____
Client / Legal Guardian Signature Date