Client Insurance Information and Acknowledgement of Notice of Privacy Practices

BOOST Kids
occupational therapy & yoga

Health Insurance: _____

Benefits Phone Number: _____

Patient's Name: _____ Member ID: _____

Patient's DOB: _____ Patient Phone #: _____

Patient's Address: _____

Physician: _____ Phone: _____

Policy holder name: _____ Policy holder DOB: _____

Relationship to child: _____

Policy holder address: _____

Policy holder phone number: _____

Employer: _____

Insured's Policy group number: _____ Member ID: _____

Secondary Insurance: _____

I consent to necessary examination procedures and/or treatment for my child by BOOST Kids licensed occupational therapists.
I authorize the release of any medical or other information necessary to process claims. I also request payment of benefits to BOOST Kids, LLC for services provided and claimed.

Parent Signature: _____ Date: _____

I have been given a copy of BOOST Kids, LLC Notice of Privacy Practices, will review it and keep it on file.

Signature: _____

I hereby give permission for images of my child, _____, captured during BOOST Kids therapy or yoga activities through video and photo to be used solely for the purposes of BOOST Kids, LLC promotional material and publications, and waive any rights of compensation or ownership thereto. I represent that I am at least 18 years of age, have read and understand the foregoing statement, and am competent to execute this agreement.

Signature: _____ Date: _____

Name of parent/guardian: _____