Client Contact and Insurance Information and Acknowledgement of Notice of Privacy Practices

BOOST Kids PEDIATRIC THERAPY

Patient's Legal Name: _____ Patient DOB: _____

Parent / Guardian Name(s): _____

Patient's Address: _____

City: _____ Zip: _____

Parent / Guardian Phone: (___) _____ Alternate phone: (___) _____

Email: _____ Subscribe to BOOST Kids newsletter? **Y N**

Health Insurance: _____

Member ID: _____ Group #: _____

Benefits Phone Number: _____

Policy holder name: _____ Relationship to child: _____

Policy holder address: _____ Zip: _____

Policy holder phone number: _____

Employer: _____

Secondary Insurance: _____

Member ID: _____ Group #: _____

Referring Physician: _____

Physician's Practice Name: _____

Physician office phone number: _____

I consent to necessary examination procedures and/or treatment for my child by BOOST Kids licensed occupational and/or speech therapists. Initial: _____

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.
BOOST Kids will submit claims to your insurance, but we do NOT guarantee coverage or payment for services. You will be billed for any portion of treatment not covered by your insurance provider. It is ultimately the responsibility of the parent/guardian to understand your child's specific insurance policy and coverage for therapy services.
Initial: _____

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

I hereby give permission for images of my child, _____, captured at BOOST Kids, 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. **Yes** **No** Initial: _____

Parent / Guardian Signature: _____ Date: _____