



Kids Therapy, Ltd.

www.kidstherapyonline.com

1860 W. Winchester Road, Suite 108
Libertyville, IL 60048
Phone: (847) 573-9486
Fax: (847) 549-6139

22285 Pepper Road, Suite 301
Lake Barrington, IL 60010
Phone: (847) 842-0597
Fax: (847) 842-9882

Date: _____

Child's Name: _____

Child's Date of Birth: _____ Male _____ Female _____

Address : _____

City/State/Zip _____

Home Phone#: _____ Email: _____

Mother's Name: _____ Date of Birth: _____

Mother's Occupation: _____

Mother's Work/Cell Phone: _____

Father's Name: _____ Date of Birth: _____

Father's Occupation: _____

Father's Work/Cell Phone: _____

Siblings Names and Ages: _____

Emergency contact person name/phone: _____



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Name of Insurance Company: _____

Name Of Policy Holder: _____ Date of Birth: _____

SS# of Policy Holder: _____

Health Ins Identification Number: _____ Group Number: _____

Responsibility For Payment:

We are pleased to provide services to your child. As a courtesy to you, we will bill your insurance company for any services provided to your child at Kids Therapy. We allow 45 days from the date of service for insurance companies to pay their portion of the claim. Your help in seeing that the claims are paid within that time frame is appreciated. If a claim is delayed because of lack of information to be provided by you to the insurance company, the claim will immediately become your responsibility. Insurance claims that are denied, rejected or not paid in full within 45 days of the date of service will immediately become your responsibility. You will receive a monthly statement for amounts that become your responsibility and unpaid charges will accrue interest at a rate of 1.5% per month. If your account is turned over to an attorney for collection you will be responsible for attorney fees incurred by Kids Therapy, Ltd.

Please sign this form below to indicate your acceptance of those terms and return it to your therapist

Signature: _____ **Date:** _____

Patient's Name: _____

Please sign below to authorize payment of medical insurance benefits directly to Kids Therapy, Ltd.

Signature: _____ **Date:** _____

Referral/Diagnosis Reason for this referral: _____ _____
Referred by: _____ _____
Does your child have a primary diagnosis? If yes, please list the primary diagnosis and any other diagnoses he/she may have: _____ _____

Primary Care Physician Primary Care Physician's Name: _____ Address: _____ City: _____ State/Zip Code: _____ Phone Number: _____ Fax Number: _____
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Additional Physician/Professional Name: _____ Address: _____ City: _____ State/Zip Code: _____ Phone Number: _____ Fax Number: _____
--

Additional Physician/Professional Name: _____ Address: _____ City: _____ State/Zip Code: _____ Phone Number: _____ Fax Number: _____
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Please List any professionals that you would like us to send reports to: _____ _____ _____ _____
