the Center for Pediatric Therapy, inc.
9 Bristol Court Wyomissing, Pa. 19610
PH (610) 670-8600 FAX (610) 670-9104
www.cptherapy.com

# INSURANCE INTAKE INFORMATION

Please fill out the information in full. Thank you for your cooperation.

Child's Name____________________________________ Date of Birth____/____/______
Last First Middle Initial

Social Security Number #__________________________________ □ Male □ Female

Mother's Name
____________________________________
Social Security # _____________________
Home Address
____________________________________
____________________________________
Home (____)_________________________
Cell (____)_________________________

Father's Name
____________________________________
Social Security # _____________________
Home Address
____________________________________
____________________________________
Home (____)_________________________
Cell (____)_________________________

Primary Doctor ______________________________________________________
Practice Name ______________________________ Phone (____) ___________
Referring Doctor________________________________ (if different than primary)
Practice Name ______________________________ Phone (____) ___________

## PRIMARY INSURANCE

Insurance Company Name___________________________________________________
ID#_________________________________ Group#_____________________________
Policy Holder______________________________________ Date of Birth___/___/______
Last First Middle Initial
Relationship to Patient: □ Mother □ Father □ Other______________ Copay $________
Employer____________________________________________________________
Employer Phone (____) ______________________

## SECONDARY INSURANCE

Insurance Company Name___________________________________________________
ID#_________________________________ Group#_____________________________
Policy Holder______________________________________ Date of Birth___/___/______
Last First Middle Initial
Relationship to Patient: □ Mother □ Father □ Other______________ Copay $________
Employer____________________________________________________________
Employer Phone (____) ______________________

Parent signature______________________________________ Date_________________

# ASSIGNMENT AND RELEASE OF BENEFITS

Child's Name ______________________________

I certify that I (or my dependent child) has health insurance coverage with the following insurance company(s):

(1.) ____________________________________________________________________

(2.) ____________________________________________________________________

I assign all insurance benefits directly to the Center For Pediatric Therapy, inc. (henceforth referred to as CPT) and authorize all payments to go directly to CPT. I also understand that certain health insurance companies may not pay CPT directly. I therefore authorize CPT to deposit checks received on the patient's account when the check is made payable to the patient.

I understand that I am financially responsible for all charges whether or not paid by insurance.

In the event that the insurance company does not pay within 90 days, I am responsible for payment in full for services provided. In the event I default under this agreement, I agree to pay collection fees and costs, including reasonable attorney's fees if CPT files a lawsuit against me to effect payment for services rendered.

I hereby authorize CPT to release medical records concerning my child's treatment programs to my primary physician and/or health insurance company as necessary to aid in the care of the patient and to secure payment of insurance benefits. I authorize the use of this signature on all insurance submissions without the need to obtain my signature on each and every claim form submitted. This signature will bind me as though I have signed each particular form.

______________________________________________________________________
(1.) PRINT Responsible Party's Name Last First Middle Initial

______________________________________________________________ __________
(1.) Responsible Party's Signature Relationship Date

______________________________________________________________________
(2.) PRINT Responsible Party's Name Last First Middle Initial

______________________________________________________________ __________
(2.) Responsible Party's Signature Relationship Date