



PO BOX 587, Lexington NC 27293  
 Phone (336) 236-6546 Fax (336) 236-9546  
 www.ot4kidsinc.com contact@ot4kidsinc.com

## INSURANCE INFORMATION

OT4K CLIENT ID# \_\_\_\_\_

Name: \_\_\_\_\_  
First Middle Last

D.O.B: \_\_\_\_\_ Sex: \_\_\_\_\_ SSN: \_\_\_\_\_

Diagnosis Codes: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

If Carolina Access, Physician listed on card: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy#: \_\_\_\_\_ Group # \_\_\_\_\_

Name of Insured: \_\_\_\_\_  
First Middle Last

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Relation to Insured: SELF CHILD

Secondary Insurance: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Insured: \_\_\_\_\_  
First Middle Last

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Relation to Insured: SELF CHILD

Tertiary Insurance: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy#: \_\_\_\_\_ Group # \_\_\_\_\_

Name of Insured: \_\_\_\_\_  
First Middle Last

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Relation to Insured: SELF CHILD

Assignment of Insurance to Therapist: I authorize direct payment of medical benefits to the attending therapist / OT4KIDS, INC. The benefits referred to herein would be payable to me if I did not make assignment and included major medical insurance. I understand that I am personally responsible to the therapist/OT4KIDS, INC. for charges not covered or paid by this assignment. I am aware that in some instances, insurance may pay me for services rendered from OT4KIDS, INC. I agree to immediately forward all such payments to OT4KIDS, INC.

The attending therapist/OT4KIDS, INC. is authorized to release any medical information required in administering applications for financial coverage for services required. He/She may also send the results of my evaluation and recommendations to my referring and/or family physical for coordination and continuity of care. I have carefully read and completed this form and to the best of my knowledge it does not contain any false, incomplete, or misleading information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

OFFICE USE ONLY - OFFICE USE ONLY - OFFICE USE ONLY - OFFICE USE ONLY - OFFICE USE ONLY - OFFICE USE ONLY - OFFICE USE ONLY - OFFICE USE ONLY	
UPIN# _____	
Carolina Access: yes _____ no _____	CDSA Sliding Scale: _____
Practice: _____	CAR Access # _____
Address: _____	Phone: _____
	Fax: _____