Insurance Information - Solo

1. Client information:

Client's First Name: ______
Client's Middle Name: ______
Client's Last Name: ______

Date of Birth: ______
Gender:
- ○ Female ○ Male
- ○ Non-binary

Street Address: ______
Apt./Unit #: ______

City: ______
State: ______
Zip Code: ______

How Did You hear About Us / Referred By: ______

Your Preferred Service Location:
- ☐ 209 Cherry St, Milford, CT
- ☐ 29 Federal Rd. Danbury, CT

INSURANCE FORM

2. PRIMARY MEMBER/POLICY HOLDER INFORMATION

Primary Insurance Company: ______
Member ID / Policy #: ______
Group Number: ______

Client Relationship to Insured:
○ Parent ○ Guardian ○ Client/Self

Policy Holder's Name: ______
Policy Holder's Date of Birth: ______

3. Do you have additional/secondary insurance?

- ○ Yes
- ○ No

4. SECONDARY POLICY HOLDER INFORMATION

Do you have any additional insurance?
○ Yes ○ No

If yes, please complete the following:

Secondary Insurance Company: ______
Member ID / Policy #: ______
Group Number: ______

Client Relationship to Insured:
○ Parent ○ Guardian ○ Patient/Self

Policy Holder's Name: ______
Policy Holder's Phone #: ______
Policy Holder's Date of Birth: ______
Policy Holder's Gender:
○ Female ○ Male

Policy Holder's Street Address: ____________________

City: ____________________

State: ____________________

Zip Code: ____________________

Policy Holder's Employer/School: ____________________

5. Please provide images of your insurance card(s), front and back.

Insurance Verification Notice

Although KidSense Therapy Group is a provider for a number of Insurance Companies, all individual companies have different coverage. This is especially true of companies that purchase insurance outside the state of Connecticut or self-funded companies.

While KidSense Therapy Group will do our best to verify your coverage, you are responsible to be familiar with your benefits, as we are not the policyholder. You are responsible for tracking any visit limits, deductibles or out of pocket limits as well as exclusions or need for medical necessity. While we endeavor to get each child covered for the services we feel are necessary, we cannot make any guarantee of insurance coverage.

If we are out of network with your insurance company and you would like to submit a claim to your out-of-network benefits, you will be expected to pay for the visit at the time of service. Our office will provide you documentation for YOU to submit to your insurance company.

Ultimately, by agreeing to receive any service provided by KidSense Therapy Group you are accepting full responsibility to cover any fees that are denied by your insurance company and authorize the release of any information concerning your child's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

You also hereby authorize payment of insurance benefits otherwise payable to you directly to KidSense and acknowledge and accept responsibility for any financial obligations that the insurance company does not ultimately cover.

https://www.kidsensetherapygroup.com/209 Cherry St. Milford, CT • 29 Federal Rd. Danbury, CT

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________________________________ ________________

Client Signature Date