Ability Occupational Therapy Services, LLC

Billing and Personal Information

Please provide photo ID & insurance cards at initial visit.

Child's Legal Name: _________________________________ Date of Birth: _______________

Parents/Guardians:

Name: _____________________ SSN#__________________DOB:____________

WK PH: ____________________HM PH: _______________ Cell: ______________

Email Address: _____________________________________

Relationship to patient: ______________________

Name: _____________________ SSN#__________________DOB:____________

WK PH: ____________________HM PH: _______________ Cell: ______________

Email Address: _____________________________________

Relationship to patient: ______________________

Address to Be Used For Billing and Records:

____

Physicians/Therapists Involved Now With Your Child:

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

If your insurance changes, please notify us before your next visit.

Primary: _____________________________________ Insured Birth Date: ___________________

Secondary: ____________________________________Insured Birth Date: ___________________

Please indicate to our office if you would prefer us to bill your insurance directly, or you file claims.
Yes, I would like your office to bill my insurance______ or No, I would prefer to bill myself.______

____ _____________________

Parent/Guardian Signature Date

Updated 5/20/2021