Patient's Name:		Date of Birth:	
Mailing Address:		Home Phone #:	
Parent/Guardian Name:		Mobile Phone #:	
E-mail address:		Alternate mobile #:	
Alternate E-mail:		Pediatrician:	
Primary Insurance:		Secondary Insurance:	
Provider info #:		Provider Info #:	
Subscriber's Name:		Subscriber's Name:	
Subscriber's DOB:		Subscriber's DOB:	
Policy ID#:		Policy #:	
Group #:		Group #:	
Employer Name:		Employer Name:	
Diagnosis (if known):			

INSURANCE BENEFIT COVERAGE (TO BE COMPLETED BY INSURANCE COORDINATOR)				
	Occupational	Physical		Notes
Annual Deductible:				
Coinsurance/Copays:				
Number of visits allowed:				
Deductible/OOP YTD:				
Authorization Required?				
Effective Date of Policy:				
Exclusions to the policy?				
Developmental Testing:				
Insurance Rep's Name:			Date of call:	

My signature indicates that all information provided above is accurate and current. I understand that if my insurance information changes at any time, it is my responsibility to notify a representative of Powerhouse Therapy *of the noted changes. Failure to do so will result in my responsibility for payment of services if insurance denies services due to lack of authorization and/or verification of benefits. Please note: verification of benefits does not ensure payment of services.*

*Signature of Parent/Guardian:*_____ *Date:*_____