OCCUPATIONAL THERAPY SERVICES
9810 F.M. 1960 Bypass, Suite 190
Humble, TX 77338
281-446-0371

PATIENT INFORMATION / FINANCIAL AUTHORIZATION

Service requested for:_____ _____ _____
Name Age Date of Birth
School:_____
Mother's Name: Father's Name:
_____ _____
Home Address:_____ Home Address:_____
_____ _____
Phone:_____ Phone:_____
Cell Phone:_____ Cell Phone:_____
Occupation:_____ Occupation:_____
Employer Name and Address: Employer Name and Address:
_____ _____
_____ _____
Phone:_____ Phone:_____
How would you describe the problem:_____
How did you find out about this service:_____
Physician:_____ **Phone:**_____
Address:_____
City State and Zip Code
Do you wish to have insurance filed: Yes_____ No_____

Insured's Name:_____ **Insured's SS#**_____
Insurance Company:_____ **Medicaid #**_____
Insurance ID#_____**Group#**_____

PERSON RESPONSIBLE FOR PAYMENT:_____
This person is responsible for the stated charges at the time of service, unless prior arrangements are made to file insurance. The responsible person also agrees to accept responsibility for any charges not paid by insurance company.

STATEMENT OF COVERAGE: I hereby attest that I do not have additional health care coverage afforded to me other than the primary insurance supplied by myself at this appointment time. I am responsible to inform this provider of all insurance changes.

***PLEASE BE SURE ALL INFORMATION IS COMPLETE.**

SIGNATURE:_____ DATE:_____

WITNESS:_____ DATE:_____