Insurance Information

Child's Name _____

Date of Birth _____ Sex _____ Age _____

Insurance Carrier _____

Policy Holder _____

Phone Number _____ Effective Date _____

Policy Number _____ Group Number _____

Secondary Insurance _____

Policy Number _____ Phone Number _____

Physician Information

Pediatrician _____ Practice _____

Phone Number _____ Fax _____

Address _____

City _____ State _____ Zip Code _____

Release of Information

I give Children In Motion permission to file with my insurance company for Occupational Therapy services and provide necessary information which could include screening results, evaluations, treatment notes, treatment plans and/or discharge summaries.

_____ _____

Parent/Legal Guardian Signature Date

Michaelene Kearney OTR/L, Pediatric Occupational Therapist

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