

# Therapy Solutions For Kids

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## Patient Information

Name of Child: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: (circle) Male or Female

Name of Parent(s) / Guardian(s): \_\_\_\_\_

### Home Address Information

Street: \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Phone Number: \_\_\_\_\_ Alternate Phone \_\_\_\_\_

Email Info: \_\_\_\_\_ Work Phone \_\_\_\_\_

### Emergency Information

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Dr. Information**

Primary Care Physician Name: \_\_\_\_\_

Clinic Name: \_\_\_\_\_

Clinic Address and Phone: \_\_\_\_\_

Other Agencies or Physicians: \_\_\_\_\_

Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: (Same as Above?) \_\_\_\_\_

Employer: \_\_\_\_\_

**Subscriber on Insurance  
Person Responsible on Account**

Concerns: \_\_\_\_\_

*I authorize Therapy Solutions for Kids to release information necessary to process my insurance claim to the insurance provider. I also authorize payment to be made directly to Therapy Solutions for Kids. I also understand that if insurance denies charges made will be my responsibility. My signature below also authorizes treatment for my child.*

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**