South Sound Pediatric Occupational Therapy
Empowering Parents and Professionals

Health Insurance Billing Information and Consent Form

Child's Name ________________________ Birthdate_______________________________

Address: _____________________________________Phone________________________

Health Insurance ______________________Benefits Phone Number____________________

Insured's Name_______________________ Insured's Date of Birth _____________________

Insured's Policy Group Number ____

Insured's Group Number:____

Other insurance____

Physician____________________________Phone__________________________________

Fax_________________________________

_____ I consent to necessary evaluation procedures and/or treatment for my child by Dawn Heino, OTR/L. I authorize the release of any medical or other information necessary to process claims. I also request payment of benefits to South Sound Pediatric Occupational Therapy for services provided and claimed.

_____ I agreed to pay South Sound Pediatric Occupational Therapy for any charges not reimbursed by my insurance including deductibles, co-pays, and co-insurance.

_____ I have been given a copy of South Sound Pediatric Occupational Therapy's Notice of Privacy Practices, and will review it and keep it on file.

Parent Signature___________________________Date______________________________

Dawn Heino, OTR/L, 2419 S. Meridian #C-16 Puyallup, WA 98373
Phone: 253-256-3192 Fax: 253-292-6739