# ***Black Hills Pediatric Therapy Patient Intake Form***

**Patient Information:**

*Last Name:*___________________________ *First Name:*_________________________

*Sex:*______________________ *Date of Birth:*__________________________________

*Address:*_________________________________________________________________

*City:*___________________________ *State:*___________ *Zip Code:*_______________

*Phone Number:* ______________________

*Physician:*______________________________ *Email:* ____________________________

**Insurance Information:**

*Insurance Co. Name:*____________________________ *Policy #:*____________________________

*Address:*_______________________________________ *City:*_______________________________

*State:*______________ *Zip Code:*__________________

Medicaid: Y / N Medicaid Number:________________________________

**Billing Policy, Release, and Authorization:**

I authorize Black Hills Pediatric Therapy to bill my insurance company directly for the covered portion of charges, and I authorize payment of benefits directly to Black Hills Pediatric Therapy. I authorize Black Hills Pediatric Therapy to release medical or other information necessary to process this claim. I understand that I am ultimately responsible for my therapy charges, and I agree to pay my deductible, my co-insurance or co-payment, and any charges not reimbursed by my insurance carrier. I understand that some insurance companies require medical or administrative pre-authorization for treatment, or have reimbursement limits on therapy treatments. I understand I am responsible for knowing and meeting the requirements of my insurance plan and/or Medicaid.

☐ I agree that my typed/electronic signature is the legal equivalent of my manual/handwritten signature on this document.

Electronic Signature: Date: