South Sound Pediatric Occupational Therapy
Empowering Parents and Professionals

Health Insurance Billing Information and Consent Form

Health Insurance: Tricare

Patient's name: _____ ID#:_____

Patient's birth date:_____

Physician_____Phone_____

Fax_____

Sponsor's name_____Sponsor's date of birth_____

Sponsor's DBN#:_____

Sponsor's Social Security #:_____

____ 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 Therapy's Notice of Privacy Practices, and will review it and keep it on file.

Parent Signature_____Date_____

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