kidsense
pediatric therapy center

315 Oak Street, Suite 200
Hood River, OR 97031
Phone: 541-386-0009Fax: 541-386-0029

FINANCIAL RESPONSIBILITY FORM

Complete all sections of this form, read the acknowledgement and any related documents, and sign/date

PATIENT'S INFORMATION

LAST NAME________________________________FIRST NAME_______________________________NICKNAME_______________________

ADDRESS____ CITY_________________________ STATE_________ ZIP____________

HOME PHONE#________________________ CELL PHONE #________________________EMAIL____________________________________

DATE OF BIRTH _____________ SEX _____ SS#_____________________ EMPLOYER____

PREFERRED METHOD OF CONTACT_______________________________ MAY WE SEND YOU KIDSENSE UPDATES/INFO VIA EMAIL? YES / NO

PRIMARY CARE PHYSICIAN____ PHYSICIAN PHONE#_____________________________

REFERRED BY ____REFERRAL SOURCE PHONE#_______________________________

EMERGENCY CONTACT INFORMATION

NAME____ RELATION TO PATIENT_______________________

ADDRESS____PHONE #____________________________________

FINANCIAL RESPONSIBLE PARTY INFORMATION (IF OTHER THAN PATIENT) ***SIGN BELOW***

NAME____ RELATION TO PATIENT______________________________________

ADDRESS____ CITY_________________________ STATE_________ ZIP____________

HOME PHONE#__________________________ CELL PHONE #________________________EMAIL____________________________________

SS#____EMPLOYER_____________________________________

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY____ PHONE#____

PRIMARY INSURED'S NAME ____RELATION TO PATIENT____________________________

PRIMARY INSURED'S ID# ____ PRIMARY INSURED'S DATE OF BIRTH_________________________

PATIENT'S ID# (IF DIFFERENT THAN PRIMARY INSURED'S)______________________________________

GROUP # _____________________________ PLAN NAME / TYPE _______________________PAYOR ID ______________________________

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY____ PHONE#____

PRIMARY INSURED'S NAME ____RELATION TO PATIENT____________________________

PRIMARY INSURED'S ID# ____ PRIMARY INSURED'S DATE OF BIRTH_________________________

PATIENT'S ID# (IF DIFFERENT THAN PRIMARY INSURED'S)______________________________________

GROUP # _____________________________ PLAN NAME / TYPE _______________________PAYOR ID ______________________________

FINANCIAL RESPONSIBILITY - ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION & ACKNOWLEDGEMENT OF PATIENT POLICIES:

By signing below, you acknowledge that:

You have read and agree with the following:

- Financial Policy*
- Patient Policies
- Privacy Practices

Kidsense will check on insurance benefits as a courtesy, however it is ultimately the Financial Responsible Party's responsibility to know the insurance benefits, including any exclusions and/or limitations in coverage.

Kidsense reserves the right to change these policies and will inform you of any changes in writing within 30 days of implementation.

Signature of Financial Responsible Party____ **Date**______________________

Print Name____