



Billing Information

Child's Name: _____ Date of Birth: _____ Gender: M F

Name of Primary Insured: _____ Date of Birth: _____ Gender: M F

Billing Address: _____

City: _____ Zip Code: _____

Email: _____ Phone: _____

Please attach a copy of your insurance card if you are in-network. Bird-Kern-Dalmia will not process insurance claims for therapy services for out-of-network clients; if you are out-of-network, please check yes if you would like an insurance claim form included with your monthly statement. insurance-claim? yes

Signature: _____ Date: _____

Privacy Policy Statement

I acknowledge I have received a copy of Bird-Kern-Dalmia & Associates Privacy Policy.

Signature: _____ Date: _____

For clinic use

Therapist: _____

Diagnosis: _____

ICD-10 Code: _____