Billing Information

Child's Name: ______________________________ Date of Birth: __________Gender: **M F**

Name of Primary Insured: ____________________ Date of Birth: __________Gender:

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. yes

Financial Responsibility Statement

I acknowledge that I am responsible for payment in full for the initial Intake Meeting and/or Complete Assessment and my insurance will not be billed; I may independently seek reimbursement from my insurance for the Intake and/or Assessment. I acknowledge that if my insurance does not pay for prescribed therapy services, for any reason, I am financially responsible and will pay in full for all services provided.

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: ____