TherapyKare
Specializing in Rehabilitation and Wellness Programs for Kids

5725 Oleander Dr. Unit A-4
Wilmington, NC 28403
Phone #:
Fax #:

PATIENT'S NAME _____ DATE _____
(LAST) (FIRST) (MI)

ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

HOME PH# _____ SEX _____ DATE OF BIRTH _____ SS# _____

PRIMARY CARE PHYSICIAN _____ PHYSICIAN PHONE# _____

INSURED'S NAME _____ SS# _____ HOME PH# _____

DATE OF BIRTH _____ EMPLOYER _____ CELL PH# _____

SPOUSE NAME _____ HOME PH# (if different) _____ CELL PH# _____

EMERGENCY CONTACT _____ ADDRESS _____ PHONE # _____

REFERRED BY _____ PHONE# _____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY _____ PHONE# _____

BILL ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURED'S NAME _____ ID# _____

GROUP # _____ HMO _____ PPO _____ PAYOR ID # _____

DEDUCTIBLE AMOUNT _____ AMOUNT MET _____ TYPE POLICY _____ CO PAY AMOUNT _____
(100%, 80/20, ETC.)

MAX VISITS _____ VISITS MET _____ POLICY PERIOD _____ AUTHORIZATION NEEDED _____

EXCLUSIONS/LIMITATIONS _____
INSURANCE REP'S NAME _____ CONFIRMATION # _____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY _____ PHONE# _____

BILL ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURED'S NAME _____ ID# _____

GROUP # _____ HMO _____ PPO _____ PAYOR ID # _____

DEDUCTIBLE AMOUNT _____ AMOUNT MET _____ TYPE POLICY _____ CO PAY AMOUNT _____
(100%, 80/20, ETC.)

MAX VISITS _____ VISITS MET _____ POLICY PERIOD _____ AUTHORIZATION NEEDED _____

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO: **Therapy Kare, Inc**

_____
(SIGNATURE OF PARENT OR LEGAL GUARDIAN)