**LARC INSURANCE FORM**

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| Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Diagnosis : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_I allow Children’s Therapy Services to access my insurance for one physical therapy session per day and one occupational therapy session per day for all days my child is in attendance. We will bill your insurance as a courtesy to you. However, it is your responsibility to assist in the prompt receipt of payment from your insurance company. You must immediately inform Children’s Therapy Services, Inc. of any changes in your insurance. Failure to notify us of changes will result in parent or legal guardian being responsible for payment. Parent or legal guardians are responsible for payment of services if insurance or secondary plan coverage does not fully cover the billed amount.  |  **Childrens Therapy Services L.L.C.** **46 Roxbury Court** **Cheshire, CT 06410****MD referral on file \_\_\_\_\_** |
| Parent Signature | Date Signed |
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| **PRIMARY INSURANCE CARRIER\*** |
| Policy Holder’s Name: | DOB: | Relationship to Child: | Health Savings Accnt ? Yes No |
| Mailing Address: |
| Insurance Company Name:Phone #: ( ) | Claim Address: |
| Member Number: | Plan Name: |
| Group Number: | Effective Date: |
| Employer: | Employer’s Address: |
| **SECONDARY INSURANCE CARRIER\*** |
| Policy Holder’s Name: | DOB: | Relationship to Child: | Health Savings Accnt ? Yes No |
| Mailing Address: |
| Insurance Company Name:Phone #: ( ) | Claim Address: |
| Member Number: | Plan Name: |
| Group Number: | Effective Date: |
| Employer: | Employer’s Address: |
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