kaleidoscope PEDIATRIC THERAPY
7211 W Franklin Rd
Boise, ID 83709
P 208-375-4200
F 208-375-4201

New Patient Intake Form

Child's Legal Name: _____ Date: _____

Nick Name: _____ DOB: _____ Age: _____ ☐ Male ☐ Female

Mother or Legal Guardian: _____

DOB: _____ SS#: _____

May our office leave Mother a message? ☐ Yes ☐ No

Home Phone: _____

Cell Phone: _____

Work Phone: _____

e-mail address: _____

May our office contact Mother by e-mail? ☐ Yes ☐ No

Appointment reminder preference: ☐ Call ☐ Text

Physical Address: _____

_____

Mailing Address: _____

_____

Employer: _____

Address: _____

_____

Father or Legal Guardian: _____

DOB: _____ SS#: _____

May our office leave Father a message? ☐ Yes ☐ No

Home Phone: _____

Cell Phone: _____

Work Phone: _____

e-mail address: _____

May our office contact Father by e-mail? ☐ Yes ☐ No

Appointment reminder preference: ☐ Call ☐ Text

Physical Address: _____

_____

Mailing Address: _____

_____

Employer: _____

Address: _____

_____

Child Resides With: _____ Who has custody of child? _____

If primary person bringing child to therapy is not listed above, please list name and contact phone number of that person.

Name: _____ Relationship: _____ Phone: _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Insurance Information

Please fill out ALL areas. Thank you.

Primary Insurance:_____

Policy Number:_____

Group Number:_____

Insured's Name:_____

Insured's DOB:_____

Secondary Insurance:_____

Policy Number:_____

Group Number:_____

Insured's Name:_____

Insured's DOB:_____

Payment Responsibility

(Complete if different than above)

Name: _____ DOB: _____

Address: _____ Phone: _____

_____

_____

Relationship to Patient: _____

I authorize Kaleidoscope Pediatric Therapy to release any clinical or financial information in person or over the phone to:

Name: _____ Relationship: _____

Signature: _____

Please Read, Sign and Date

Kaleidoscope Pediatric Therapy agrees to bill most insurance carriers, if all necessary information is provided. I, the patient or legal representative, agree to be financially responsible for all charges whether or not paid for by insurance and my responsibility to understand my benefits. I understand it is my (legal representative) responsibility to inform KPT of any insurance changes in any manner. I will be responsible for my charges accrued during this time if denied by my insurance for lack of providing timely information to KPT. For delinquent accounts, a collection agency will be used. I assign to Kaleidoscope Pediatric Therapy permission to bill my insurance company and release information pertaining to claim submittal. I acknowledge receipt of the patient intake brochure which includes: Release of Liability; Notice of Privacy Practices; Patient Responsibilities; and Patient Financial Responsibilities. *If Responsible Party is unable to sign, please indicate.*

Signature: _____ Date: _____

Signers Authority/Relationship: _____

I have read and renewed and reviewed the above contract. All information is accurate and current. By signing below, I agree to the aforementioned policies and conditions.

Signature: _____ Date: _____

Signers Authority/Relationship: _____

Signature: _____ Date: _____

Signers Authority/Relationship: _____