Sande Rutstein, OTR/L
Pediatric Occupational Therapist
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Client Information Sheet

Patient Name: _________________ **(M / F) DOB:** __________ **Age:** ____ **School:**___________

Parent Name(s):____

Guarantor Name: __________________________________ **DOB:** _______________________

Home Address_____________________ **City**_______________ **State:** ___ **Zip:** ____________

Home PH#: _____________________ **Cell/Other PH #:**_________________________

Parent Employer: ____________________________ **Work PH#:** _______________________

Email Address: ____

Referring Provider: ______________________ **Dr Phone:** _____________________

Primary Insurance Company Name:____

ID/Subscriber Number# _______________________ **Group No #:**_________________________

Address: ____

Name of **Responsible Party** if different than Patient ____

DOB: __________ **SS#:**_______________ **Employer**: _________________________________

Private Health Insurance:

It is ***your*** responsibility to know the benefits and limitations of your particular insurance policy. For insurance companies that we do not contract with the services rendered with be your responsibility at the Usual & Customary rates for this area. ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE.

****Twenty-four hours notification is requested when canceling and appointment. Thank you!**

*I **authorize** the release of **any medical** or other information necessary to process claims on my behalf. I agree to be **fully responsible** for all lawful debts incurred by myself for services received from **Sandra Rutstein, OTR/L** whether covered by insurance or not.*

I have read, understand, and **agree** to the above stated financial policies. I consent to therapeutic treatment and services rendered, which include those modalities and/or procedures prescribed by my physician. I hereby state that the information I have provided is true and correct to the best of my knowledge.

Parent Signature: ___________________________ **Date:** ______________________