



## CONTACT INFORMATION

Date: \_\_\_\_\_

Child's information
Name:
Mailing address:
Home phone number:
Parent/Caregiver's contact information
Name:
Address (if different from above):
Employed by:
Home phone number:
Work phone number:
Cell phone number:
Email address:
Parent/Caregiver's contact information
Name:
Address (if different from above):
Employed by:
Home phone number:
Work phone number:
Cell phone number:
Email address:



## CREDIT CARD PAYMENT INFORMATION

I hereby authorize Chattering Children to charge my credit card for the purpose of all services rendered and equipment on behalf of myself or my child, \_\_\_\_\_.

I understand that the charges to the below referenced credit card account will be based on charges that are due and payable at the time of the credit card transaction.

I understand that this agreement is between myself and Chattering Children.

Name as it appears on card: \_\_\_\_\_

Type of Card: (circle one)                      VISA                      MASTER CARD

Account Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

CVT CODE (3 digit security code/back of the card) \_\_\_\_\_

Cardholder Signature: \_\_\_\_\_

Credit Card billing address: \_\_\_\_\_

\_\_\_\_\_

Telephone number: \_\_\_\_\_

Today's Date: \_\_\_\_\_



## INSURANCE INFORMATION

Client's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

INSURANCE	PRIMARY	SECONDARY
Company Name:		
Subscriber's Name:		
Subscriber's Date of Birth:		
Insurance Mailing Address:		
Member ID #:		
Group #:		
Provider's Phone #:		

**\*\*\*\* PLEASE INCLUDE A COPY OF YOUR INSURANCE CARD**

**Please read carefully and sign below.**

I authorize Chattering Children to bill directly my/our insurance for services and/or durable medical equipment (DME) rendered. I understand that if an insurance payment is not received within 90 days of billing, Chattering Children will bill me for the amount, which will become due immediately. If after I pay the charges and an insurance payment is received at a later date, Chattering Children will credit my account and issue a refund. I understand that, under certain circumstances, therapy may be suspended until an overdue account is settled.

Signature of Client or Parent/Guardian: \_\_\_\_\_

Name (print): \_\_\_\_\_

Date: \_\_\_\_\_

**Office Use Only:**  
 Rep: \_\_\_\_\_  
 Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Initials: \_\_\_\_\_