Suburban Pediatric Therapies
Treating kids right through excellent service

Patient Information Form

Suburban Pediatric Therapies, PC
3965 75th Street, Suite 104
Aurora, IL 60504

Patient Information

First Name

Last Name

Gender ◯ Female ◯ Male

Date of Birth

Phone Number

E-mail

Primary Physician Name

Phone Number

Relationship to Guarantor ◯ Self ◯ Child ◯ Other

Other

Patient Address

Address

Address (Line 2)

City

State

ZIP Code

Guarantor Information

First Name

Last Name

Date of Birth

Guarantor Address

Address

Address (Line 2)

City

State

Zip Code

Phone Number

Guarantor Work Information

Employer Name

Address

Address (Line 2)

City

State

Zip Code

Phone Number

Guarantor Spouse Information

First Name

Last Name

Date of Birth

Guarantor Spouse Work Information

Employer Name

Address

Address (Line 2)

City

State

Zip Code

Phone Number

Emergency Contact Information

First Name

Last Name

Relationship to Guarantor

Address

Address (Line 2)

City

State

Zip Code

Phone Number

Insurance and Billing Information

Primary Insurance Company	
Insured	
ID #	
Group #	
Address	
Secondary Insurance Company	
Insured	
ID #	
Group #	
Address	

AUTHORIZATION TO RELEASE INFORMATION:

I HEREBY AUTHORIZE SUBURBAN PEDIATRIC THERAPIES, PC TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO FILE AND/OR PROCESS MEDICAL CLAIMS WITH MY INSURANCE COMPANY(S) ON MY BEHALF.

ASSIGNMENT OF BENEFITS:
I HEREBY AUTHORIZE DIRECT PAYMENT OF MEDICAL BENEFITS TO SUBURBAN PEDIATRIC THERAPIES, PC FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO SUBURBAN PEDIATRIC THERAPIES, PC FOR CHARGES NOT COVERED BY THIS ASSIGNMENT. IN SOME CASES, OUR FEE IS NOT COVERED IN FULL BY YOUR INSURANCE COMPANY. THIS BALANCE DUE INCLUDES PROVISIONS SET BY YOUR INSURANCE COMPANY SUCH AS CO-PAYMENTS, DEDUCTIBLES AND “USUAL AND CUSTOMARY” ALLOWANCE.

GUARANTEE OF PAYMENT:
IN CONSIDERATION OF ALL MEDICAL SERVICES GIVEN BY SUBURBAN PEDIATRIC THERAPIES, PC TO THE PATIENT NAMED BELOW, I AGREE TO PAY SUBURBAN PEDIATRIC THERAPIES, PC ALL FEES AND CHARGES MADE FOR SERVICES. I UNDERSTAND THAT SHOULD MY ACCOUNT BE PLACED IN COLLECTIONS FOR NON-PAYMENT; I AM RESPONSIBLE FOR ANY FEES SUCH AS: AGENCY FEES, COURT COSTS AND ATTOURNEY FEES

I HEREBY CERTIFY TO YOU THE FOREGOING INFORMATION IS TRUE AND COMPLETE. I HAVE READ AND HEREBY AGREE TO BE BOUND BY THE TERMS OF THESE AGREEMENTS AS SET FORTH. A PHOTOCOPY OF THESE ASSIGNMENTS SHALL BE AS VALID AS THE ORIGINAL.

Date

Print Name

Signature