MOSAIC Patient and Insurance Information

Bellevue Location
MOSAIC Children's Therapy Clinic
13010 N.E. 20th Street, Suite 300
Bellevue, Washington 98005
Phone (425) 644-6328
Fax: (425) 644-6295

Seattle Location
MOSAIC Children's Therapy Clinic
2111 N Northgate Way, Suite 101
Seattle, Washington 98133
Phone: (206) 388-3751
Fax: (206) 556-4515

Issaquah Location
MOSAIC Eastside Children's Therapy Clinic
1495 NW Gilman Boulevard, Suite 4
Issaquah, Washington 98027
Phone: (425) 392-2346
Fax: (425) 392-0185

PATIENT INFORMATION

Patient Name: ______________________ Date of Birth: __________ ☐ M ☐ F
Last First M.I

Parent(s)/Caregiver/ Responsible Party — Phone Number(s)

	Home	Work	Cell	Email
Name:				
Name:				
Caregiver Contact Information:	Name			❒ Please DO NOT include my email for MOSAIC's newsletters

Address: ______________________ ______________ ______________
Street City Zip

Caregiver/ parents are: ❒ Married ❒ Separated ❒ Divorced Parenting Plan? ❒ Yes ❒ No (*Please provide copy of parenting plan if restrictions apply)*

Secondary Address: ______________________ ______________ ______________
Street City Zip

PHYSICIAN'S INFORMATION

Primary Physician: ______________ Address: ______________
Phone: ______________

Referring Physician/Provider: ______________ Address: ______________
Phone: ______________

☐ *Same as above*

INSURED'S INFORMATION (PLEASE PROVIDE PRIMARY POLICY HOLDER INFORMATION)

Is your child covered under DSHS? ❒ Yes ❒ No Which DSHS coverage? ❒ Open Coupon ❒ Molina

Insured's Name: ______________ D.O.B. __________ ☐ M ☐ F
Last First

Employer: ______________ Member I.D: ______________

Insurance Company: ______________ Group I.D: ______________

Insurance Address: ______________ Effective Date: ______________

______________ Insurance Phone #: ______________

SECONDARY INSURANCE INFORMATION (PLEASE PROVIDE SECONDARY INSURANCE INFORMATION)

Does your child have DSHS as secondary insurance? ❒ Yes ❒ No Which DSHS coverage? ❒ Open Coupon ❒ Molina

Insured's Name: ______________ D.O.B.: __________ ☐ M ☐ F
Last First

Employer: ______________ Member I.D: ______________

Insurance Company: ______________ Group I.D: ______________

Insurance Address: ______________ Effective Date: ______________

______________ Insurance Phone #: ______________

Assignment and Release:

I hereby authorize MOSAIC Rehabilitation to release any information required by appropriate agencies or insurance companies. I understand that as a courtesy MOSAIC Rehabilitation has contacted my insurance company to see what Neurodevelopmental and Rehabilitation Benefits apply to my plan and I do not hold MOSAIC Rehabilitation responsible for the information received. I also authorize my insurance benefits to be paid directly to MOSAIC Rehabilitation and I am financially responsible for any unpaid balance.

I declare the foregoing information is true and correct.

______________________ ______________________
Responsible Party Signature Date

______________________ ______________________
Print Name (Responsible Party) Witness (to be signed by MOSAIC Staff Member)