 Information for Contact and for billing

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| Child's name: Sex: M F DOB |
| Address: (house number, street, city, state, zip code) |
| Please provide the following and circle the way you prefer to be contacted:  Home phone: Cell: Work E-mail |
| Name of Parent/Guardian |
| Just in case, please provide us with the an emergency contact number other than your own  Name of person to contact Relationship  Phone number: |
| Physician Name  Address:  Phone We will call your physician for a prescription. |
| Primary Insurance  Insurance plan name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insured's name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB  First Middle initial Last  Insured’s ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insured's employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Please attach a copy of the front and back of your insurance card. You will also need to present this at the time of your initial visit.  *Please note that you will need to call your insurance to find out if your plan covers speech therapy, your copay and deductible balance. We will be contacting your insurance, but you need to know your benefits. Insurance doesn’t guarantee payment and you will be billed for services that your insurance doesn’t cover.* |
| Patient's or authorized person's signature:  I authorize the release of any medical or other information necessary to process this claim. I also request payment of benefits directly to Therapedics.  Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:  Printed name: |

2015