

Insurance Policy Information

Client Name: _____ Client # : _____

Date of Birth: ____ / ____ / ____ Social Security Number: ____ - ____ - ____

Primary Insurance:	
Primary Policy Holder's Full Name:	
Policy Holder's Date of Birth:	
Policy Holder's Social Security Number:	
Policy Number / Contract Number:	
Group Number:	
Group Name:	
Speech Therapy Service Co-Pay:	

Secondary Insurance:	
Secondary Policy Holder's Full Name:	
Policy Holder's Date of Birth:	
Policy Holder's Social Security Number:	
Policy Number / Contract Number:	
Group Number:	
Group Name:	
Speech Therapy Service Co-Pay:	

As the client or as a guardian of the client I understand that in some cases, certain services will be denied payment from my insurance company due to limitations of my personal policy. In the case that my insurance company denies payment for this service, I understand that I am fully responsible for the payment of services.

Speech Therapy
SOLUTIONS

126 Brass Oak Drive
Madison, AL 35758
256.683.7135

X _____ / / _____
Signed (Client or Guardian of Client) Date