

HEALTH INSURANCE BILLING CONSENT FORM

Insurance Name: _____

Patient Name: _____

Patient's Date of Birth: _____ **Member ID:** _____

Patient's address: _____

Physician: _____ **Phone:** _____

Parent/Guardian Name: _____

Parent/Guardian Date of Birth: _____ **Member ID:** _____

Parent/Guardian Phone Number: _____ **Employer:** _____

Insurance policy group number: _____

Any other insurance: _____

I consent to necessary examination procedures and/or treatment for my child by Talya Smith, MA, CCC/SLP-L.

I authorize the release of any medical or other information necessary to process claims. I also request payment of benefits to Speech Learning Center for services provided and claimed.

Parent/Guardian signature: _____ **Date:** _____

I have been given a copy of Speech Learning Center's Notice of Privacy Practices, will review it and keep it on file.

Signature: _____