NYCSPEECH-LANGUAGE PATHOLOGIST

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INSURANCE INFORMATION

Patient's Name (Please Print): _____

Patient's Address: _____

Date of Birth:_____ Phone:_____

Email Address:_____ Social Security#: _____

Insurance Company Name:_____

Insurance ID#:_____ Group#:_____

Number of visits per year:_____

Do you have a deductible? ☐ Yes ☐ No Amount of deductible: $_____

Amount of co-pay: $ _____ or percent of client responsibility _____

Is referral/prescription required? ☐ Yes ☐ No (If yes, please hand it in immediately.)

Is pre-Authorization required? ☐ Yes ☐ No

Credit card number (MasterCard or Visa):_____

Exp. Date: _____Security Code:_____ (three or four digit code in front or back of card)

Credit Card info. will not be used unless payment is not made.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical service, or as the responsible part for minor patients. Your signature verifies that you have read the above statement and understand your responsibilities and agree to these terms.

Date: _____

Responsible Party Name (please print): _____

Responsible Party Signature: _____