



Insurance Information

CLIENT INFORMATION

*Client Name: _____ Date of Birth: _____

*Client Address: _____
(Address) (City) (State) (Zip)

*Home Phone: _____ *Sex: M F

*Student: FT PT No Where: _____ *Social Security #: _____

*Relationship to the Guarantor: _____

INSURED INFORMATION

*Insured Name: _____

*Insured Address: _____
(Address) (City) (State) (Zip)

*Home Phone: _____ *Sex: M F

*Student: FT PT No Where: _____ *Marital Status: S M D W Other _____

*Work Status: FT PT Retired Self-Emp Not Emp

*Insured Employer: _____

Work Address: _____
(Address) (City) (State) (Zip)

Work Phone: _____ *Social Security #: _____

REFERRING PHYSICIAN

*Referring Physician: _____ Address: _____

*Phone: _____
(City) (State) (Zip)

*Referral Number: _____

Other Referral Source (Name): _____ Phone: _____



PRIMARY INSURANCE INFORMATION

***Primary Insurance Company Name:** _____

***Address:** _____

City _____ State _____ Zip _____

Contact Name: _____ ***Phone:** _____

***ID Number:** _____ ***Policy Holder:** Self Other

***Date of Accident/Injury/Illness:** _____

***AUTHORIZATION**

I hereby authorize the release of any medical or other information necessary to process this claim.
I also request payment of government benefits either to myself or to the party who accepts assignment.

***Signed:** _____ **Date:** _____

I hereby authorize payment of medical benefits to Childhood Speech & Language for services rendered. I also understand I am financially responsible for any balance not covered by my insurance carrier.

***Signed:** _____ **Date:** _____