**Speech Therapy on the Go! Inc.**

**Insurance Verification Form**

**PATIENT INFORMATION**

|  |  |
| --- | --- |
| Name of child | First: Last: |
| Date of Birth | Gender: M / F |
| Address |  |
| City, State, Zip |  |
| Home Phone |  |
| Phone/Email/Fax |  |
| Language(s) spoken in the home |  |
| Mother/Guardian | First: Last: |
| Phone # |  |
| Father/Guardian | First: Last: |
| Phone # |  |
| Pediatrician’s Name |  |
| Pediatrician Phone/Fax |  |
| Concerns: |  |
|  |  |
|  |  |

**INSURANCE INFORMATION**

|  |
| --- |
| Name of Insurance: |
| Name of Insured |
| ID # Group # |
| Member Services Phone # |
| Relationship to Insured |
|  |

**ASSIGNMENT AND RELEASE**

**I certify that I (or my dependent) have insurance coverage with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and assign directly to Amanda Foutch/Speech Therapy on the Go! Inc. all insurance benefits. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I authorize the use of this signature to release medical records to primary physician and/or Health Insurance Company.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Responsible Party’s Signature Relationship Date**