Bauer
STUTTERING & SPEECH
THERAPY, LLC

Providing In-Home Services

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Patient Insurance Information & Authorization

Primary Insurance:

Patient Name:_____ DOB:_____

Insurance Company:_____ Phone:_____

ID Number:_____ Group Number:_____

Policy Holder:_____ DOB:_____

Copayment: $_____ Prior Authorization #_____

Visits Authorized:_____per calendar year or other:_____

Secondary Insurance:

Insurance Company:_____ Phone:_____

ID Number:_____ Group Number:_____

Policy Holder:_____ DOB:_____

Copayment: $_____ Prior Authorization #_____

Visits Authorized:_____per calendar year or other:_____

I, _____(please print) certify that my child _____ has insurance coverage with_____ (insurance company) and assign directly to Bauer Stuttering & Speech Therapy, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Bauer Stuttering & Speech Therapy, LLC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Parent/Guardian Signature Date