Team Speech

Health Insurance Information and Consent Form

Child/Patient's Name:		**DOB:**	
Address:			
Prmary Care Physician:		**Phone:**	
Practice:			

Primary Insurance:			
Child/Patient's Member ID:		**Policy Group #:**	
Benefits Phone Number:			
Primary Policy Holder:		**DOB:**	
Primary Holder Address:			
Primary Holder Phone:			
Primary Holder Member ID:			
Employer:			

Secondary Insurance:			
Child/Patient's Member ID:		**Policy Group #:**	
Benefits Phone Number:			
Primary Policy Holder:		**DOB:**	
Primary Holder Address:			
Primary Holder Phone:			
Primary Holder Member ID:			
Employer:			

I give my consent for Team Speech to submit claims to my private or public health insurance for services and I authorize my insurance company to make payments to this service provider.

Parent Signature: ______________________________ **Date:** __________________