SPEECH LEARNING CENTER

**HEALTH INSURANCE BILLING CONSENT FORM**

**Insurance Name:** _____

**Patient Name:** _____

**Patient's Date of Birth:** _____ **Member ID:** _____

**Patient's address:** _____

**Physician:** _____ **Phone:** _____

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**Parent/Guardian Name:** _____

**Parent/Guardian Date of Birth:** _____ **Member ID:** _____

**Parent/Guardian Phone Number:** _____ **Employer:** _____

**Insurance policy group number:** _____

**Any other insurance:** _____

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**I consent to necessary examination procedures and/or treatment for my child by Talya Smith, MA, CCC/SLP-L.**

**I authorize the release of any medical or other information necessary to process claims. I also request payment of benefits to Speech Learning Center for services provided and claimed.**

**Parent/Guardian signature:** _____ **Date:** _____

**I have been given a copy of Speech Learning Center's Notice of Privacy Practices, will review it and keep it on file.**

**Signature:** _____