Atlantic Speech Therapy
1430 Commonwealth Dr. Suite 300|Wilmington, NC 28403|Phone: 910.343.5885|Fax: 910.343.5886 |info@atlanticspeechtherapy.net

Insurance Information

Please answer all questions

Patient Name: _____ DOB: _____

Person Responsible for Payment: _____

Relationship to Patient: _____

Insurance Company Name/Address/Phone Number:

_____
_____
_____
_____

Primary Insured's Name: _____

Primary Insured Social Security Number: _____

Primary Insured Date of Birth: _____

Insurance Policy Number: _____ Group Number: _____

Other Insurance Information: _____

I hereby authorize Atlantic Speech Therapy to furnish information to insurance companies concerning my treatment. I hereby assign Atlantic Speech Therapy all payments for services rendered to my dependents and/or myself. I understand that I am responsible for any amount of service not covered by my insurance company. This will include, but not be limited to, any deductibles, co-pays, co-insurance, and any denied services. In addition, I understand that verification of benefits does not guarantee payment from my insurance carrier.
(Please be aware that your insurance claim may take up to thirty days to process (longer for specific types of insurance). You will be invoiced once your claim has been processed with your insurance company, and is due upon receipt, unless a prior written payment plan has been agreed upon.)

In signing this policy notice, I acknowledge that I have read and fully understand that I will be held responsible for any fees that my insurance company states not covered by policy or patients responsibility.

Signature of Patient, Parent or Legal Guardian: _____

Date: _____