chattering children
More than just talk.

INSURANCE INFORMATION

Client's Name: _____ Date of Birth: _____ Gender: _____

INSURANCE	PRIMARY	SECONDARY
Company Name:		
Subscriber's Name:		
Subscriber's Date of Birth:		
Insurance Mailing Address:		
Member ID #:		
Group #:		
Provider's Phone #:		

****** PLEASE INCLUDE A COPY OF YOUR INSURANCE CARD**

Please read carefully and sign below.

I authorize Chattering Children to bill directly my/our insurance for services and/or durable medical equipment (DME) rendered. I understand that if an insurance payment is not received within 90 days of billing, Chattering Children will bill me for the amount, which will become due immediately. If after I pay the charges and an insurance payment is received at a later date, Chattering Children will credit my account and issue a refund. I understand that, under certain circumstances, therapy may be suspended until an overdue account is settled.

Signature of Client or Parent/Guardian: _____

Name (print): _____

Date: _____

Office Use Only:
Rep: _____
Comments: _____
_____
_____
_____
Initials: _____