LAKESHORE SPEECH THERAPY INSURANCE

PATIENT INFORMATION	
Patient Name	
Patient Birthdate	
Policy Holder's Name	
Policy Holder's DOB & Employer Name	
PRE-AUTHORIZATION	
Pre-Authorization Required	Yes No
If yes, name of third party's visit manager:	
INSURANCE INFORMATION	
Insurance Name	
Insurance ID Number	
Insurance Policy Number	
Deductible Amount:	
Number of Speech Visits/Insurance Year:	

FINANCIAL OBLIGATION

I, ____, as parent/guardian/policy holder, understand the following:

***It is my responsibility to know what my speech benefits are according to my plan.**

***If there is a deductible to first meet, there are out of pocket costs. All out of pocket costs will be paid within 45 days of the date of service.**

***Copays/co-insurances are due at the time of each service date.**

***Once insurance visits are depleted, I am responsible for charges in full.**

Signature	Date