Simplified Speech Solutions, LLC

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AAC • Consultation • Diagnostics • Therapy

Consent to Bill Insurance

Client Name:_____ **Date of Birth**:_____

I, _____, understand my insurance company will be billed on the client's behalf and I am responsible for all fees, deductibles, co-payments, and any unpaid portion of any bill. Payment in full is due at the time of service unless other arrangements have been made.

I authorize the release of any information including the diagnosis and the records of any treatment or evaluations rendered for the above listed client during the period of such care to third party payers and/or other health practioners.

I authorize and request my insurance company to pay directly to Simplified Speech Solutions, LLC insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on the above listed client's behalf.

Primary Insurance Company Name_____

Policy Holder's Name: _____

Policy Holder's Date of Birth:_____ **ID Number:** _____

Secondary Insurance Company Name_____

Policy Holder's Name: _____

Policy Holder's Date of Birth:_____ **IDNumber:**_____

_____ _____

_____ _____

Signature of Person completing Form Date