



The Speech Language Learning Center

Patient's Insurance Information

Please present your insurance card so we may make a copy for your records

Patient's Name _____ Date of Birth _____

PLEASE NOTIFY US IF ADDRESS IS DIFFERENT THAN PATIENTS!

Person responsible for bill _____

- Subscriber's Name _____
- Subscriber's S.S. number _____
- Subscriber's Date of Birth _____
- Policy number _____
- Group number _____

Patient's relationship to subscriber:

- Self
- Spouse
- Child
- Other

*****Name of secondary insurance (if applicable):

- Secondary Subscriber's Name _____
- S.S. number _____
- Date of Birth _____
- Policy number _____
- Group number _____
- Patient's relationship to secondary subscriber:
 - Self
 - Spouse
 - Child
 - Other

The above information is true to the best of my knowledge. I understand that I am fully financially responsible to The Speech Language Learning Center, Inc. for charges not covered by my insurance. I also authorize The Speech Language Learning Center, Inc. or insurance company to release any information required to process my claims.

Patient/guardian signature

Date