Billing Information

Patient Name: _____ Date of Birth _____ Gender: M F

Policy Holder Name(s): _____

Billing Address: _____

City: _____ Zip Code: _____

Phone Number:_____ Email: _____

Name of Primary Insured: _____ Date of Birth: _____ Gender: M F

Member ID # _____ Group ID #_____

Phone Number of Plan: _____ Insurance Company: _____

Secondary

Patient Name: _____ Date of Birth _____ Gender: M F

Policy Holder Name(s): _____

Billing Address: _____

City: _____ Zip Code: _____

Phone Number:_____ Email: _____

Name of Primary Insured: _____ Date of Birth: _____ Gender: M F

Member ID # _____ Group ID #_____

Phone Number of Plan: _____

Financial Responsibility Statement

I acknowledge that IF my insurance does not pay for services, for any reason, I am financially responsible and will pay in full for all services provided.

Signature: _____ Date: _____

Therapist Providing Evaluation and Treatment: Ashley S. Fairleigh, M.S. CCC-SLP

Therapist's Signature: _____ Date: _____