Therapy Corps
Speech & Language Therapy Services

Billing Information

Child's Name: _____ Date of Birth _____ Gender: M F

Parent's 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: _____

Therapy Corps, PLLC will process insurance claims for in-network clients only; if you are in-network, please include a copy of your insurance card. Out-of-network clients are responsible for processing their insurance claims; IF you are out of network, please circle YES if you would like an insurance claim form included in your billing statement.

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: _____