Premier Pediatric Therapy
"Lighting the way to a brighter future"

Billing Consent
Required

Insurance Information:

Insurance Company: _____

ID Number & Group Number: _____

Name of Insured: _____

Employer: _____

Insured DOB: _____

Email Address: _____

Authorization/Release and Payment Agreement:

I understand that my private insurance may not cover speech and/or language evaluation and therapy; therefore I understand that I am financially responsible for all charges not covered by my insurance at the time service is rendered. I also hereby authorize payment (if applicable) from my insurance to go directly to Premier Pediatric Therapy, P.A. otherwise payable to the insured. In addition, I willingly authorize Premier Pediatric Therapy, P.A, to release information requested by my insurance company in order to support my claim.

Credit Card Billing Information			
Your Name:		Enter CVC Number (3 digit code on back of card):	
Credit Card Number:			
Expiration Date:			
Billing Address:			
City:		State:	Zip Code:
Telephone Number:		Email Address:	

I agree that all the information provided is accurate and complete. By signing below, I authorize that my credit card be charged for uncovered services, late cancellations, "no shows" and/or copays provided by Premier Pediatric Therapy, P.A.

Please notify Premier Pediatric Therapy, P.A. of any changes to the status of this card and/or to request a change in payment agreement at (561) 670-4864 or premierped@comcast.net

_____ _____

Authorized Signature Today's Date

_____

(Print) First and Last Name