Financial Obligations/Insurance Information

Patient Name: _____ DOB:_____

Name of Parent of Legal Guardian: _____

INSURANCE

Dynamic Pediatric Speech Therapy, LLC (DPST) will make every effort to verify your child's insurance benefits and assure that we have all necessary documentation in place prior to initiating services. These efforts are provided as a service at no charge to our clients and families, however, it is ultimately the policy holder's responsibility to assure that their child is receiving services which are reimbursable by his/her insurance policy.

Primary Insurance Carrier: _____Effective Date: _____

Policy Number: _____ Group Number: _____

Policy Holder's Name: _____ Date of Birth: _____

Employer: _____Insurance Phone (Providers): _____

Secondary Insurance Carrier: _____Effective Date: _____

Policy Number: _____Group Number: _____

Policy Holder's Name: _____ Date of Birth: _____

Employer: _____Insurance Phone (Providers): _____

Georgia Medicaid Number: _____ Effective Date: _____

Your child's insurance coverage may change periodically. Some insurance policies require specific referrals, particularly HMO's,. Failure to provide updated information in a timely fashion may result in your child receiving treatment that may not be reimbursable under his or her policy.

_____ I authorize the release of any information necessary to process insurance claims.
(Initials)

_____ I authorize my insurance carrier to issue payment of benefits directly to Dynamic Pediatric Speech Therapy, LLC.,
(Initials) Kimberly Turner-Rogers, M.A., CCC/SLP. I recognize that certain charges may not be covered by my child's medical insurance, and that I am financially responsible for all charges incurred.

_____ I acknowledge that if I fail to disclose changes in insurance coverage that results in non-reimbursable
(Initials) charges with my child's primary, secondary, or tertiary insurance carrier, or with Georgia Medicaid, that I am financially responsible for all charges incurred.

This agreement shall remain in effect for a period of no less than one year from date signed. Please provide an updated agreement, as well as a copy of your child's insurance card, with all changes in coverage.

Signature of Parent/Legal Guardian: _____ Date: _____