

INSURANCE INFORMATION

For therapy clients only – Please fill this form out in its entirety and provide copies of the front and back of the insurance cards listed below. *(The front desk can make copies of your cards if needed)*

Student Name _____

Parent's Names _____

Address _____

Primary Insurance:

Insurance Company _____

Address _____

Policy Holder _____

Policy Holders Social Security # _____ Date of Birth _____

Policy Number _____ Group Number _____

Secondary Insurance:

Insurance Company _____

Address _____

Policy Holder _____

Policy Holders Social Security # _____ Date of Birth _____

Policy Number _____ Group Number _____

ACCESS Group Inc. will file your insurance for you. However, this does not guarantee that your insurance company will pay for the therapy services. You are ultimately responsible for the payment due on all services.

I hereby authorize ACCESS Group Inc. to furnish information to my insurance company concerning the care of my child. I assign all payments for services rendered to my child to the above. I understand that I am ultimately responsible for the payments due on all services.

Parent/Guardian Signature

Date

My child does not receive therapy services.