Special Therapies, Inc.

Assisting Development and Wellness Throughout the Lifespan

INSURANCE VERTIFICATION FORM

Patient Name: _____

Parent/Guardian name: _____

Address: _____

City: _____State: _____Zip: _____

Home phone: _____ Cell phone: _____ Other phone: _____

Patient Date of Birth: _____ / _____ / _____

PRIMARY INSURANCE CARRIER: _____

Insurance Address: _____

City: _____State: _____Zip: _____

Insurance Telephone: _____ _____

Subscriber's Name (policy holder): _____

Subscriber's Date of Birth: _____ Subscriber's SS#: _____

Subscriber's Employer: _____

Policy Number: _____

Group #: _____

Effective Date: _____

Your insurance is a method for you to receive reimbursement for fees for services rendered to you and your dependent(s) by Special Therapies, Inc. Having insurance is not a substitute, nor a guarantee of payment. Many insurance companies have fixed allowances or percentages based upon your contract with them. We accept insurance assignments from companies who are not regulated by networks.

We will assist you in receiving reimbursement as much as possible, but you are ultimately responsible for your bill. *We do not accept assignment, therefore any reimbursement from your insurance company will be sent to you directly*.

I understand and attest that I have obtained information about my insurance coverage for the services I am seeking from Special Therapies, Inc. I am aware of my responsibility for payment of services, co-payments, and deductibles that are incurred.

I authorize Special Therapies, Inc. to submit claims on my / my child's behalf.

Signature: _____**Date**: _____