# Thrive Speech Pathology

## Insurance Authorization Form

**Insurance Information**

Name of Insurance Company: _____

Policy Number: _____

Group Number: _____

Benefits Phone Number: _____

Name of Policy Holder: _____

Policy Holder DOB: _____

Relationship to Patient: _____

Child Name and DOB: _____

**Primary Care Physician Information**

Primary Care Physician:_____

Phone Number: _____ Fax Number:_____

Address:_____

**Authorization**

If you would like for us to file your claims, please read the authorization statement and sign below:

I, _____, authorize Thrive Speech Pathology to contact my doctor regarding any information that is deemed relevant to my plan of care. I also authorize the release of any medical or other information necessary to process insurance claims related to speech therapy services provided by Thrive Speech Pathology.

I authorize the payment of medical benefits to Thrive Speech Pathology for speech therapy services provided to me. I recognize that in the event that my insurance company does not pay for services rendered, I am fully responsible for all payments due.

Signed: _____

Date: _____