allcare Therapy Services, LLC
OCCUPATIONAL, SPEECH, PHYSICAL & ABA THERAPY

INSURANCE INFORMATION

As a courtesy we will bill your primary insurance carrier if you provide **ALL** necessary information (such as insurance cards with their **CORRECT** billing address and **REFERRALS**). Co-pays are collected for each visit at the time of service.

Statement of Financial Responsibility

I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. **I understand I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance.**

PRIMARY INSURANCE

Insurance Name: _____

Claims Address: _____

Policyholder Name: _____

Policyholder DOB: _____ Marital Status: _____

Policyholder Social Security #: _____

Policyholder ID: _____

Patient ID: _____

Group #: _____

Signature of Legal Guardian: _____

For billing purposes we require this form to be fully completed. We reserve the right to reschedule any appointments due to incomplete forms or tardiness. Thank you for your cooperation.