Staten Island Speech & Counseling

Heath Insurance Billing Consent Form

Health Insurance:_____

Benefits Phone Number:_____

Patient's Name:_____Member ID:_____

Patient's Birth Date:_____Patient's Phone:_____

Patient's Address:_____

Physician:_____Phone:_____

Sponsor's Name:_____Sponsor's Birth Date:_____

Sponsor's Address:_____

Sponsor's Phone:_____Employer:_____

Member ID:_____Group Number:_____

Other Insurance:_____

I consent to necessary examination procedures and/or treatment for me/my child by Karen Corbo, SLP-CCC/Jeremiah Corbo MSEd, LMHC.

I authorize the release of any medical or other information necessary to process claims. I agree to turn over **all payments of benefits** received from my insurance company to Staten Island Speech for services provided.

Parent signature:_____Date:_____

I have been given a copy of Staten Island Speech's Notice of Privacy Practices, will review it and keep it on file.

Signature:_____ Date:_____

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