MidState Therapy Associates
Speech & Occupational Therapy For Children and Adults

## Insurance Information

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|---|---|---|
| **Client Name:** | **Parent/Guardian Name:** | |
| **DOB:** | **Age:** | **Sex:** |
| **Address:** | | |
| **City:** | **State:** | **Zip code:** |
| **Phone:** | **Cell:** | |
| **Email:** | | |

| | |
|---|---|
| **Primary Insurance:** | |
| **ID #:** | **Group #** |
| **Name of Insured:** | **DOB:** |

| | |
|---|---|
| **Secondary Insurance:** | |
| **ID #:** | **Group #** |
| **Name of Insured:** | **DOB:** |

**I acknowledge that the information that I have provided is true and correct. I hereby authorize my insurance carrier and/or myself to make payment directly to MIDSTATE for services rendered to my dependents or me. I understand that I am fully responsible for any charges incurred for services rendered as well as any costs or fees incurred for collection of this account. I hereby of myself/and or my dependents. I authorize MIDSTATE to initiate a complaint to Insurance Commissioner on my behalf.**

**Client Signature (or caregiver for minor)** | **Date**

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