MidState Therapy Associates
Speech & Occupational Therapy For Children and Adults

Insurance Information

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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