Commencement
CHILDREN'S THERAPY

Insurance Verification Form

Child's Name: _____ **Date of Birth:** _____

Address: _____

_____ Phone: _____

Primary Insurance: Insured's Name: _____ Date of Birth: _____

Insurance Company: _____

Policy Number: _____

Group ID: _____ Phone: _____

Deductible? Yes No Amount: _____ Has been met? Yes No

Co-pay Amount _____

Secondary Insurance: Insured's Name: _____ Date of Birth: _____

Insurance Company: _____

Policy Number: _____

Group ID: _____ Phone: _____

Deductible? Yes No Amount: _____ Has been met? Yes No

Co-pay Amount _____

Referred by: _____ **Diagnosis**: _____

Limitations in Coverage: _____

_____

I understand that it is my responsibility to obtain a physician referral with a diagnosis code and insurance authorization of benefits confirming Commencement Children's Therapy, LLC, as a contracted provider with my insurance plan. I acknowledge that I have verified insurance benefits with my insurance plan prior to receiving services from Commencement Children's Therapy, LLC. I understand I am financially responsible for all services rendered, co-pays, co-insurances, deductibles, and/or anything that my insurance company does not cover or reimburse. It is my responsibility to understand and follow the contract limitations of my insurance coverage. I will pay my account within a timely manner, whether insurance reimburses or not, and will be responsible for additional costs if collection actions are required. I will notify Commencement Children's Therapy, LLC, regarding any changes in my insurance coverage or benefits.

Signature: _____ Date: _____

Print Name: _____ Relationship: _____

P. 253.284.0386 | F. 253.284.0384 | Shari@CommencementChildrensTherapy.com

2915 North McCarver St, Suite 100, Tacoma, WA 98403 | www.CommencementChildrensTherapy.com