Payment Agreement

Patient Information

Patient Name	
Date of Birth	Age:
Address	
Phone Number	
PCP/Referred by	

Parent/Guardian Information

Parent/Guardian Name	Phone Number	Email Address	Relationship

Preferred Method of Payment (check preferred method)

☐ Primary Source of Insurance

Name of Insurance	
Policy Holder	
Member ID / Policy Number	
Group Number	

☐ Secondary Source of Insurance

Name of Insurance	
Policy Holder	
Member ID / Policy Number	
Group Number	

☐ Private Pay / Out of Pocket Option

Payment Agreement

☐ I request and authorize my insurance company(s) to make payments of authorized benefits on my behalf to Bright Speech Therapy. I agree that office co-pays and any amount not paid for by my insurance becomes my obligation. If my insurance is not in-network, I agree to pay all service fees on the day that services are rendered.

Signature of Parent/Guardian Date

9995 Florida Blvd. Walker, LA 70785 | tel: 225-283-5797 | fax: 225-425-3468
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