the madison center
pediatric speech & occupational therapy

insurance information form

Primary Source of Insurance

Insurance Address

Insurance Phone

Policy Holder | Member ID / Policy Number | Group Number

Secondary Source of Insurance

Insurance Address

Insurance Phone

Policy Holder | Member ID / Policy Number | Group Number

account payment

◯ I request and authorize my insurance company and/or Medical Assistance to make payments of authorized benefits on my behalf to The Madison Center.

I agree that office co-pays and any amount not paid for by my insurance becomes my obligation.

/ /

Signature of Parent/Legal Guardian | Date