THE VOZ INSTITUTE

Insurance Information Form

Thank you for choosing The Voz Institute as your therapy provider!

Speech, occupational, physical and any other therapy sessions are not always a covered benefit with your insurance company and may not be considered medically necessary. A quote of benefits/verification of coverage from your insurance company that we provide is not a guarantee of payment and should therapy sessions be denied, the patient/family is ultimately responsible for payment. You are also responsible for payment of any deductible, coinsurance, or copayment as applied by your insurance. If your insurance plan has a deductible that applies to services rendered, we will let you know upon a verification of coverage (VOC), but we will not charge you until we receive your EOBs. If your account is ever sent to outside collections for non-payment, you will also be financially responsible for any collection fees.

The patient/caregiver is also responsible for disclosing ALL insurance plans listed under their name or the patient's name. If you have a primary or secondary insurance, you must disclose this with our office PRIOR to starting services or you will be held responsible for any outstanding payments collected by the insurance company.

By submitting this form, you are providing consent to The Voz Institute's medical billing team to contact your insurance company on your behalf for information about coverage of the service(s) provided. We thank you for the opportunity to help you and your family!

PLEASE SEND A COPY (FRONT AND BACK) OF ALL INSURANCE CARDS TO INFO@VOZSPEECHTHERAPY.COM AFTER FILLING OUT THIS FORM ELECTRONICALLY. IF INSURANCE INFORMATION AND A COPY OF THE CARDS ARE NOT RECEIVED AT LEAST 24 HOURS BEFORE YOUR SCHEDULED APPOINTMENT, THE SESSION WILL AUTOMATICALLY BE RESCHEDULED.

Primary Insurance Name: _____

Employer and Group Name: _____

Insurance Identification Number (please include all letters and hyphens): _____

Insurance Group Number: _____

Insurance Provider Phone Number: _____

Secondary Insurance Name: _____

Secondary Employer and Group Name: _____

Secondary Insurance Identification Number (please include all letters and hyphens): _____

Secondary Insurance Group Number: _____

Referring Physician Name and Number (if applicable): _____

Primary Care Physician Name and Number: _____

What is the best time and method for us to contact you regarding scheduling and/or your benefits? Please include a preferred phone number or email, and any times/dates that work best for your schedule: _____

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By signing this form, you are providing consent and acknowledging that the information provided is correct to the best of my knowledge and is legally binding.

_____ _____

Signature Date

_____

Relationship to Patient