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Primary Source of Insurance

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Insurance Address

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Insurance Phone

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Policy Holder

Member ID / Policy Number

Group Number

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Secondary Source of Insurance

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Insurance Address

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Insurance Phone

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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: *(Please check appropriate box)*

*speech therapy*  
 The Madison Center

*occupational therapy*  
 Therapeutic Frameworks Inc.

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

/ /

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Signature of Parent/Legal Guardian

Date