Clough Consultants and Speech Therapy, INC

Insurance Form

This form must be submitted prior to evaluation along with your case history form and physician's order. Please contact your insurance for co-pay amount and number of approved visits per year.

Client Name: _____

Private Pay? Yes _____ No _____

Insurance Company Name: _____

ID #: _____

Group #: _____

Policy Holder's Name: _____ DOB: _____

Policy Holder's Employer: _____

Relationship to Client: _____

*Number of Approved Visits per year: _____

*Ins. Calendar Year- starts/ends _____/_____ (example: Jan 1/Dec. 31)

*Deductible? Yes _____ No _____ *If yes, Amount $ _____

*Co-pay/ Co-insurance per session: $_____

How do you prefer to be contacted in the event that a cancellation needs to be made?

_____