Patient Name _____ Date of Birth _____

INSURANCE INFORMATION

Primary Insurance Company _____
Secondary Insurance Company _____

COURTESY INSURANCE BENEFIT VERIFICATION

Insurance eligibility and estimated insurance benefit information is provided as a courtesy to our patients, but it is not intended to release you from total responsibility for your account balance. This is only an **estimate** of the amount due from you**.** The attached summary of your current insurance benefits was verified on _____ by _____.

ACCOUNT GUARANTOR (person(s) financially responsible for patient account)

Guarantor Full Name _____ DOB: _____
Social Security Number _____-_____-_____ Primary Phone (_____)_____
Street Address (no PO Box) _____ Apt/Suite _____
City _____ State _____ Zip _____
Employer _____ Employer's Phone (_____)_____

ASSIGNMENT OF INSURANCE BENEFITS

As the account guarantor, I assign to Jump Start Pediatric Therapy all insurance benefits held on the patient's behalf for therapy services rendered by Jump Start Pediatric Therapy. I understand that Jump Start Pediatric Therapy has the right to refuse or accept assignment of such benefits. If these benefits are not assigned directly to Jump Start Pediatric Therapy, I agree to forward to Jump Start Pediatric Therapy all health insurance benefits and other third-party payments that I receive for services rendered by Jump Start Pediatric Therapy immediately upon receipt.

_____ Parent/Guardian Initial

RECIEPT AND ACKNOWEDGEMENT OF FINANCIAL POLICIES

I have read Jump Start Pediatric Therapy's Financial Policies, and I agree to the conditions stated. **I understand and accept my responsibility for the timely payment of my account.**

_____ Parent/Guardian Initial

_____
Printed Name of Patient

_____
Printed Name of Account Guarantor

_____
Signature of Account Guarantor Initials Date