Cincinnati Center for Improved Communication, Inc.

Services in Speech, Language, and Language-Based Learning Disorders

C.C.I.C. Billing and Insurance Information

Patient's Name: _____ Date of Birth: _____ Sex: M F

Patient's Address: _____

City: _____ State: _____ Zip: _____

Telephone (include area code): _____

Patient's Relationship to Insured _____ Self _____ Spouse _____ Child _____ Other

Patient's Status _____ Single _____ Married _____Other

_____ Employed _____Student _____Full-time _____Part-time

Name of Physician/Pediatrician: _____

Address: _____

Telephone: _____

Insured's ID/SS Number: _____

Insured's Name (last, first, middle initial): _____

Insured's Address: _____

City: _____ State: _____ Zip: _____

Telephone (include area code): _____

Insured Policy Group or FECA Number: _____

Insured's Date of Birth: _____ Sex: _____ Male _____ Female

Employer's Name: _____

Insurance Plan Name or Program Name: _____

Is there another Health Benefit Plan? ____ Yes ____ No

I authorize payment of medical benefits to be paid directly to C.C.I.C.

_____

Parent/Patient Signature Date

I understand that if for any reason payment for services is not received within 90 days, I will be responsible for any charges for services rendered.

_____

Parent/Patient Signature Date

For us to submit claims to insurance companies, we must have a photocopy (front and back) of the patient's insurance card.

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