Scottish Rite Childhood Language Center
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AUTHORIZATION FOR INSURANCE BILLING

By signing this document, I agree to assign the Scottish Rite Childhood Language Center any and all health care benefits to which my child is entitled under my policy of insurance and authorize, to the extent permitted by law, payment of those benefits directly to the Scottish Rite Childhood Language Center.

By signing this document, I authorize the release to my insurance company any medical information which may be necessary to determine coverage and approval. I acknowledge and agree that the Scottish Rite Childhood Language Center will use, maintain, secure and disclose my child's records only in accordance with the provisions of Virginia law governing the privacy and confidentiality of patient's medical records.

If the Scottish Rite Childhood Language Center is a provider with my insurance carrier, I authorize the submission of claims on my behalf. I understand that I am required to pay any co-payments at the time of service. I understand I am responsible for paying the balance after insurance has paid their portion. In the event the insurance carrier does not pay within 3 months from the date of service, I understand I must pay the balance.

In the event that my insurance carrier does not authorize treatment, I am responsible for all charges for services.

I understand if **I do not have health insurance**, I may apply for financial assistance from the Scottish Rite Childhood Language Center. If I do not choose to apply for financial assistance I am responsible for paying, at the time of service, all charges incurred.

_____The Scottish Rite Childhood Language Center has my permission to bill my insurance carrier for communication services received by my child.

_____ I do not have health insurance and/or coverage for communication services and would like information regarding the Scottish Rite Childhood Language Center's Financial Assistance Program.

______________________________ ____________
Signature of Parent or Guardian **Date**

______________________________ ____________
Witnessed by **Date**

Revised 07-20-2020