**Insurance Waiver**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ am responsible for reimbursement of fees generated by Premier Speech Therapy for evaluation and/or therapy services if they are in fact NOT covered by my insurance company, to be paid in full within 30 days of billing date.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Patient/parent/guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Witness Date