J5 Therapy, Inc.
PO Box 1419 Alexander, AR 72002
Phone: 501.602.1168 Fax: 844.272.0941
www.j5therapy.com

Authorization Form

Speech: [ ]
Occupational: [ ]

Name:	Date:
Signature:	
Insurance Company:	

Consent to Test

- I give J5 Therapy, Inc. permission to conduct a therapy evaluation for my child. I also give my permission for treatment, if testing results and the child's primary care physician reveal it is needed.

Medicaid Release and Assignment

- I request that authorized Medicaid Payments be made to J5 Therapy, Inc. for any services provided by them to my child.

Insurance Assignment and Release

- I verify that my child is insured and that J5 Therapy, Inc. receives all insurance benefits, if any, otherwise payable to me for services, rendered. I understand that I am responsible only for the deductible, coinsurance, and noncovered services. I understand that my signature, whether manual or electrical, requests that payment be made and authorizes release of medical information necessary to pay the claim.

Privacy Policy Agreement

- Your privacy is important to us. We create information about you so we may provide you with quality care, and we are committed to protecting this information. I have received a copy of the privacy policy.