Wright Therapy Group, LLC
& Therapy Consortium, Inc.
609 N. Main Street, Suite 106
Marion, SC 29571
Phone/Text: 843-289-5211
Fax 843-874-0850
info@WrightTherapyGroup.com

Patient Health Insurance Verification Form

Patient Name: _____ Date of Birth: _____

Primary Insurance: _____ Phone Number: _____
Member Name:_____ Employer:_____
Member ID #: _____
Group Number#: _____
Effective Date: _____ /_____ /_____

Secondary Insurance: _____ Phone Number: _____
Member Name:_____ Employer:_____
Member ID #: _____
Group Number#: _____
Effective Date: _____ /_____ /_____

Please provide front and back copies of most recent/up to date insurance card(s).

I do hereby attest that this information is true, accurate, and up to date and I understand that any falsification, omission, or concealment of information may subject me to liability. Furthermore, should *Wright Therapy Group, LLC* incur any charges, recoupment of payment, etc. due to my lack of providing accurate information, I take full responsibility and will be held financially liable for the fees *Wright Therapy Group, LLC* incurs.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____