Medicaid Release

Parent/Guardian Authorization

I _____, Parent/Guardian of _____, give permission for my child to receive an evaluation and/or therapy services provided by Chatterbox Pediatric Therapy Center, LLC. In addition, I give permission for Chatterbox Pediatric Therapy Center, LLC to bill Medicaid for _____'s evaluation and/or treatment services. Please sign below stating that you have read the above mentioned Medicaid release and agree to the terms:

Signature: _____

Date: ____/__/____

Child's Full Name: _____

Medicaid Number: _____

** Make Copy of Medicaid Card