Therapeutic Time Inc.

Insurance Release

Date of Birth	Litt		ित्रा				ŕ.	1.1.
State Zip Code	SS#	Date of Birth		S e z	c: M/	F Mar	ital Status	
Email address: Primary Insurance Information Date of Birth SS# Insurance Name Policyholder Name Group# Relationship to Policyholder: Self Spouse Child Other Employer Name City State Zip Insurance of emergency contact Phone Relationship Insurance Name Relationship to Policyholder: Self Spouse Child Other Employer Name City State Zip Insurance of emergency contact Phone Relationship Insurance of the terms, conditions, limitations and exclusions under the members policy, including the ent's effective status on the actual date of service. Final determination will be made once the complete of the status on the actual date of service. Final determination they might need to complete the provider of claims submitted on my behalf. I authorize my insurance company to send all beneately to the provider. Insurance Information Policyholder Phone Pho	Home Address					Apt#_		
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