The Gift of Speech

Patient (Child) Information

Name: _____
DOB: _____Age: _____Concern/Reason for Referral: _____
Home Phone #_____Work #_____
Address: _____
Who referred you? _____
Recent Illness/Medical History: _____
_____
Parent(s) Name: _____

Please answer the following questions concerning recent services.

Y or N Recurrent ear infections?
Y or N Hearing Evaluations? By Whom? _____ Date? _____
Y or N Currently Receiving Speech Therapy? By Whom? _____ Date? _____
Y or N Currently Receiving Occupational Therapy? By Whom? _____ Date? _____
Y or N Currently Receiving Physical Therapy? By Whom? _____ Date? _____

What are child's hobbies or interests? _____
_____
_____

Insurance Information

Primary
Insurance Carrier:_____ Group #: _____
Member ID: _____ Plan Member Name: _____
Plan Address: _____ Plan Phone #: _____
_____
_____
_____

If duel covered, please provide both cards and Information.

Secondary
Insurance Carrier: _____ Group #: _____
Member ID: _____ Plan Member Name: _____
Plan Address: _____ Plan Phone #: _____
_____
_____
_____

FINANCIAL RESPONSIBILITY

Each patient (or responsible party) is financially responsible for services rendered. While we are pleased to assist in the preparation or submission of insurance forms, the obligation for payment of our fees remains that of the patient, and we urge prompt payment within thirty days. 2% will be added to all balances not cleared within 30 days (24% per annum). Should there be any question concerning our fees or terms, please don't hesitate to ask.

INSURANCE ASSIGNMENT

I hereby authorize payment directly to the undersigned physician of the surgical and or medical benefits, if any, otherwise payable to me for his services but not to exceed the reasonable and customary charge for these services. I understand that I am financially responsible for the charges not covered by this authorization.

Date:_____ Signature: _____