Registration Form

Speech and Language Connections

DX Code _____

Date _____ Therapist _____

Patient Information

Patient Name (Print)_____ Date of Birth _____
Last Name First Name Initial

Street Address_____Home Phone _____

City_____State_____ZIP_____ Cell Phone _____

Sex: Female Male Age_____ Parent Name(s)_____

How did you hear about Speech and Language Connections?_____

Referring Physician Name_____Referring Physician Phone_____

Primary Physician Name_____ Primary Physician Phone _____

Primary Insurance Primary Insurance Primary Insurance Primary Insurance

Primary Insurance Company_____ Phone _____

Ins Claims Address_____City_____State_____Zip_____

Policy / Member ID _____ Group/Account #_____

Policy Holder Information: (if the patient is not the employee/policy holder)

Name_____ Date of Birth _____
Last Name First Name Initial

Address_____City_____State_____Zip_____Relationship_____

Soc. Sec#_____Employer_____

Secondary Insurance Secondary Insurance Secondary Insurance Secondary Insurance

Secondary Insurance Company_____ Phone _____

Ins Claims Address_____City_____State_____Zip_____

Policy / Member ID _____ Group/Account #_____

Policy Holder Information: (if the patient is not the employee/policy holder)

Name_____ Date of Birth _____
Last Name First Name Initial

Address_____City_____State_____Zip_____Relationship_____

Soc. Sec#_____Employer_____

Responsible Party (Where should the patient's portion of the bill be sent, if not to the patient?)

Name _____Relationship _____

Address_____Phone _____

Assignment and Release Assignment and Release Assignment and Release Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date