

# 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 Appointment Text Reminders Y / N

Referring Physician Name (first and last) \_\_\_\_\_ Referring Physician Phone \_\_\_\_\_

How did you hear about Speech and Language Connections? \_\_\_\_\_

Primary Physician Name \_\_\_\_\_ Primary Physician Phone \_\_\_\_\_

Primary Clinic Name \_\_\_\_\_ Primary Physician Fax \_\_\_\_\_

### ***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 \_\_\_\_\_

Employer \_\_\_\_\_ Phone Number \_\_\_\_\_

### ***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 \_\_\_\_\_

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