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 ______________ Mom's Cell Phone ______________________

Sex: Female Male Age ________ Parent Name(s) ______________________ Dad's Cell Phone ______________________

Appointment Text Reminders Yes No Which Cell Phone ______________

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 ______________________

## *Secondary Insurance Secondary Insurance Secondary Insurance Secondary Insurance*

Secondary Insurance Company ______________________ Phone ______________________

## *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