

Speech and Language Connections

Registration Form

Date: _____

Therapist: _____

Patient Information

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

Street Address _____ Home Phone: _____

City _____ State: _____ ZIP: _____

Sex: Female Male

If minor, Mother's Name: _____ Cell phone: _____

Father's Name: _____ Cell phone: _____

Would you like appointment Text Reminders Y / N If Yes, which cell number?

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 Company _____ State: _____ Phone: _____

Policy / MemberID _____ Group/Account# _____

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

Name _____ Date of Birth: _____
Last Name First Name Initial

Employer _____ Phone: _____

Secondary Insurance

Secondary Insurance Company _____ State: _____ Phone: _____

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

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

Name _____ Relationship: _____

Address _____ Phone: _____

Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to Speech and Language Connections all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges for services provided regardless of any insurance coverage. I hereby authorize Speech and Language Connections 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