SPEECH SPOT LLC
Children's Speech Therapy

2017 Registration Form

PATIENT INFORMATION:				
Last Name:		First:		Middle:
Birth date: / /		Age:	Sex: (circle) M F	
Parent(s) / Guardian(s) Name:				
Street Address:			P.O Box	City:
State:	ZIP Code:	Best Phone Number:		2nd Phone Number:
Preferred method of contact: ❑phone call ❑text ❑ email _____ ❑any ❑other:				
How did you hear about us?				

INSURANCE INFORMATION :	
Is this patient covered by insurance? ❑ Yes ❑ No	
1. Please indicate <u>primary</u> insurance: ❑ Blue Cross/Blue Shield ❑ Regence/Blue Shield ❑Aetna ❑ Dakota Care ❑ United Health Care ❑ Cigna ❑ Medicaid ❑Tricare ❑Pacific Source ❑ Select Health Other: _____	
Last Name on Policy: First:	*Subscriber's Birth Date (Must have):
Policy or Member ID Number:	Employer:
Patient's Relationship to Policy Holder: ❑ Self ❑ Child ❑Other: _____	
2. Please indicate <u>secondary</u> insurance (if applicable): ❑ Medicaid Other: _____	

Last Name on Policy: First:	**Subscriber's Birth Date:
Policy or Member ID Number:	Employer:
Patient's Relationship to Policy Holder: ❑ Self ❑ Child ❑Other: _____	

- I authorize Speech Spot LLC or my insurance company(s) to release any information required to process my claims.
- I authorize my insurance benefits be paid directly to Speech Spot LLC.
- If insurance is to be billed, I understand they will be billed first and then co-payments or percentages are due as by the 20th of the month the invoice was received unless otherwise arranged.

Initials _____.

PAYMENT INFORMATION:

- Statements are mailed/given at the beginning of each month.
- I understand payment is due by the 20th of the month the invoice is received.
- I understand a 25.00 late fee may be charged to payments received after the 20th of the month the invoice was received unless other arrangements have been made.
- I understand 2.5% interest may be applied to balances greater than 30 days. I understand that I am financially responsible for any balance or any balance my insurance does not cover.
- We accept cash, personal checks and credit/debit card payments.
- There is a $35.00 charge on all returned checks. I am also responsible for any costs associated with collecting payment for my account.
- I would like to receive invoices by email ❑ yes ❑ no thanks

Initials _____.

AUTHORIZATION:

I give permission for Speech Spot LLC to conduct an evaluation and/or provide speech therapy services for _____.

The above information is true to the best of my knowledge.
I will notify Speech Spot LLC of any changes to the above information.

_____ _____

Signature of Patient or Parent/Guardian Date