

PATIENT INFORMATION

Date _____

Patient Name _____
(Last) (First) (Initial)

Date of Birth _____ Age _____ Male Female Previous Name(s) _____

Address _____
(Street) (City) (Zip)

Home Phone _____ Work _____ Cell _____

Referred By _____ Family Doctor _____

PARENT OR LEGAL GUARDIAN'S INFORMATION

Name _____ Last 4 S.S. # _____

Employer _____ Occupation _____

Work Phone _____ Length of Employment _____

Spouse Name _____ Last 4 S.S. # _____

Address (if different) _____
(Street) (City) (Zip)

E-mail Address _____

Information may be released to : Spouse _____ Other _____

INSURANCE

****Please attach a copy of the front and back of your insurance card(s).**

Primary Medical Insurance

Co. Name _____

Insured Person _____ DOB _____

Effective Date _____

Secondary Medical Insurance

Co. Name _____

Insured Person _____ DOB _____

Effective Date _____

- I authorize release of any medical information necessary, and authorize payment of medical benefits to the provider, from my insurance company. I also authorize the release of any medical information necessary to any doctors that we may be referred to. I understand any charges incurred are my responsibility, regardless of insurance status.
- I acknowledge that I may be charged a \$25 fee for sessions that are missed without advance notice or are canceled on the same day. This fee cannot be billed through insurance. In the event that this fee is incurred, it will be billed directly to me as an out-of-pocket expense. Speech Tree reserves the right to waive this fee under extenuating circumstances (e.g., illness, emergencies).

SIGNATURE _____

DATE _____