PATIENT REGISTRATION FORM

General Information:

Patient Name: _____Date of Birth: ___ / __ / ___
Mailing Address: _____ City: _____ Zip Code: _____
Phone: (____) _____Cell: (___)_____
email: _____
Mother/Guardian Name: _____ D.O.B.: _____
Employer/Phone: _____
Father/Guardian Name: _____
Employer/Phone: _____ D.O.B.:_____
Emergency/Same-Day Contact (outside of household):
Name _____
Relationship _____ Phone _____

Medical Information:

Child's Primary Care Doctor: _____ Phone: _____
Diagnosis: _____ Date _____

Allergies/Medical Conditions?

_____
_
_____
_

Insurance/Payment Information:

Please include copy of insurance card or ID card**
Circle the following: 1-**Medicaid** / 2-**VPK SIS** / 3-**Private Insurance** / 4-**Gardiner Scholarship** / **6-Private Pay**
ID Number: _____
Insurance Company Name: _____
Name Insured: _____ D.O.B.:_____
Policy Number: _____ Group Number: _____
Annual Deductible: _____ Co-Payment: _____

Are you aware whether your insurance provides for: _____ YES _____ NO
If YES, please indicate which one:
____Speech-Language therapy _____Occupational Therapy _____ Physical Therapy

Are you aware of any limitations in regard to your coverage for therapy services?

_____
_

Parent/Patient Agreement / Treatment Authorization – Please INITIAL
I am seeking Therapy services from Theraspeech, Inc. for my child. I understand that:

1) Theraspeech will bill insurance weekly as a professional courtesy _____
2) Theraspeech is not an In-Network provider for some private insurance companies _____
3) I am responsible for the entire amount, less what my private insurance reimburses Theraspeech Inc. _____
4) I will be responsible for any amount not paid by the insurance company _____
5) A credit card/debit card form must be completed to deduct any payment due _____
6) Theraspeech will collect co-pay/fee for service at the time of service. Tx will not be provided otherwise _____
7) Full session fee will be charge for 'No Shows' or cancellation made less than 3 hours before scheduled session. A fee of $35 will be charges for cancellations up to 3 hours _____.

I will be responsible for advising Theraspeech Inc. if there should be any changes in my/my child's insurance coverage, physicians, other health care providers, or participation in other programs. I also understand that my appointment times are specifically reserved for me and, that I am responsible for keeping them.
When at all possible, I will notify Theraspeech Inc. **3 hours** in advance to cancel an appointment, otherwise a **$35 fee** will be charged.

_____
Parent/Guardian Signature **Date**

Insurance Authorization:

I assign payment of authorized benefits and/or government benefits to be made to Theraspeech, Inc, on my behalf, for any services provided to my child, _____. I authorize any holder of medical and other information about my child, to release to any insurance company, any other third party payer, state medical assistance agency, or any other governmental or private payer responsible for paying such benefits, any information needed to determine these benefits
or benefits for related services. By signing below, I agree to pay for all charges not covered and paid by a third party payer. I understand that all charges 45 days past due may be subject to collections and I agree to pay for all costs associated with the collections process. I authorize a copy of this authorization to be used in place of the original.

_____

Parent/Guardian Signature **Date**

Release of Medical Record:

In order to facilitate follow-up and continuity of my child's care, I authorize a copy of my child's, _____, medical record may be released to my child's physician, a designated referral physician, and/or the provider, if any, who is involved in the care of my child. I also authorize the release of any verbal discussion about my child's treatment with other professionals or caregivers involved in my child's care/well-being. Furthermore, I identify the following, in advance, to be authorized as above:

Name: _____ Relation: _____
Phone:_____

Name: _____ Relation: _____
Phone:_____

Name: _____ Relation: _____
Phone:_____

Parent/Guardian Signature **Date**

WELCOME!!!