

Associated Speech & Language Specialists, LLC

PATIENT INFORMATION

"This information is confidential"

Provider	DX
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Clinic Location: St. Paul Arden Hills Plymouth
 Maplewood (Circle One) Today's Date: _____

Patient Name – Last, First, MI				
Address			Home Telephone	
City-State-Zip Code			Cell Telephone	
Sex Male Female	Age	Date of Birth	Social Security Number	Marital Status (Circle One) Single Married Widowed Divorced

****** PLEASE FILL OUT PARENT/GUARDIAN INFORMATION BELOW ******

Patient / Parent / Guardian	Employer	Business Telephone
Spouse	Employer	Business Telephone
Local Friend/Relative <u>not</u> at same address	Telephone ()	Relationship
Who referred you? • Physician • Friend/Patient-Name _____ • Yellow Pages • Other: _____		
Primary Physician: Name _____ Clinic _____ Telephone _____		
Address _____ City _____ State _____ Zip Code _____		

INSURANCE INFORMATION – Please show your card to the receptionist. If you are unable to provide this information, you will be responsible for filing claims to your insurance company.

Primary Insurance	Group #	Policy #	Policy Holder Name	Policy Holder Date of Birth:
Insurance Company Address	City	State	Zip Code	Telephone
Secondary Insurance	Group #	Policy #	Policy Holder Name	Policy Holder Date of Birth:
Insurance Company Address	City	State	Zip Code	Telephone

I AGREE TO PAY Associated Speech and Language Specialists, LLC for the services provided. I am responsible for all charges regardless of insurance coverage. As a courtesy, Associated Speech & Language Specialists will submit my claims to insurance. However, I will be financially responsible for all charges, whether or not paid by my insurance company. I understand that it is my responsibility to contact my insurance company to verify speech benefits & to confirm the required referral or authorization is in place prior to receiving speech services. If my insurance denies coverage as "not medically necessary" I will be responsible for the denied charges. I also understand that if, at any time, my insurance policy or company changes, I will be solely liable for any and all charges insurance denies that are a result of the change.

 Signature

_____/_____/_____
 Date

Associated Speech and Language Specialists LLC. DOES NOT accept UCARE, TriCare, MA, Tefra, or Medicare as primary or secondary insurance.

Treatment Authorization – I hereby authorize Associated Speech & Language Specialists, LLC, or their designee(s), to treat my or the patient's condition as they deem appropriate. Records Release on File with Clinic

Assignment of Benefits – I hereby assign the authorized benefits and direct that payment under any insurance policy or health benefits plan to be made directly to Associated Speech & Language Specialists, LLC for any services rendered to me by or on behalf of Associated Speech & Language Specialists, LLC

I have received a copy of Associated Speech and Language Specialists Notice of Privacy Practices with an effective date of April 14, 2003

FOR ALL OF THE ABOVE INFORMATION: _____

SIGNATURE

DATE