Associated Speech & Language Specialists, LLC

PATIENT INFORMATION

"This information is confidential"

Provider	DX

Clinic Location: St. Paul Shoreview Plymouth Maplewood
(Circle One) Today's Date: _____

Patient Name – Last, First, MI	
Address	Home Phone
City-State-Zip Code	Cell Phone

Sex Male Female	Age	Date of Birth	

Physician Name and Clinic _____ I hereby authorize you to release medical information about me to my physician [ ] Yes [ ] No	Phone

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

Patient / Parent / Guardian	Employer	Business Phone
Spouse	Employer	Business Phone
Email		

Local Friend/Relative not at same address	Phone	Relationship
Who referred you? ☐ Physician ☐ Friend/Patient-Name_____ ☐ Other: _____		

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

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***

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 & Language Specialists Notice of Privacy Practices with an effective date of September 23, 2013

FOR ALL OF THE ABOVE INFORMATION: _____ _____
SIGNATURE **DATE**

www.associatedspeech.com

Revised: 8/29/12, 3/1/13, 10/15/13, 6/30/14