Speech & Language Stimulation Center, Inc.

slsc@frii.com Phone: 970.495.1150 Fax: 495-0133

CLIENT NAME:_____ Today's Date:_____

Address:_____
Street City State Zip Code

Home #:(_____)_____Work:(_____)_____Cell:(_____)_____

*We will leave messages at the above number unless otherwise instructed.

Fax:(_____)_____ Email:_____

Date of Birth:_____ Age:_____ Social Security #: only upon request

Occupation:_____ Employer:_____

Your physician: _____

SPOUSE/PARTNER NAME:_____

Who would we call in case of emergency?_____
NAME PHONE NUMBER

Who referred you to us, or how did you find out about our practice?_____

_____

Any other critical information we should know?_____

_____

INSURANCE INFORMATION:

Do you have health insurance? YES NO (circle one)

Who's your Primary Insurance:_____

Secondary Insurance:_____

OFFICE ONLY: ☐ Copy of Insurance Card Taken

FEE POLICY:

Payment is due at time of service. Insurance is for the purpose of reimbursing the patient. We will gladly help you complete insurance forms although this fee contract is directly with you. Total fees for evaluations and therapy vary depending on time involved. **A session includes 5-10 minutes of chart writing and preparation time. We will bill for appointments canceled less than 24 hours in advance (unless emergency occurs).** You will be billed for any charges through our bookkeeping office. An interest fee of 1.5% will be charged for balances more than 30 days old. You will be given more specific information in writing about these policies.

CONSENT FOR TREATMENT AND UNDERTAKING TO PAY FEES:

I authorize all licensed therapists employed by the Speech & Language Stimulation Center, Inc. to perform speech-language diagnostic evaluations and treatments as appropriate and necessary; I agree to pay all of the charges for such procedures upon receipt of the statement. I agree to allow Speech & Language Stimulation Center, Inc to release my billing information (including diagnoses) to a third party for purposes of collection, and agree to pay all costs of collection including reasonable attorneys' fees if applicable.

_____ _____

SIGNATURE OF RESPONSIBLE PARTY DATE