



**Big Apple Speech Therapy, LLC**  
**8060 E. Gelding Dr. Suite C-107 Scottsdale, Arizona 85260**  
 INTAKE FORM



Date: \_\_\_\_\_ Diagnosis: \_\_\_\_\_  
 (for office use only)

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_

Patient Address: \_\_\_\_\_  
(Address) (City) (State) (Zip)

Home Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M F Marital Status: S M D Other \_\_\_\_\_

*Notify in Case of Emergency* \_\_\_\_\_  
(Name) (Phone number) (Address, City, State, Zip)

Referred By: \_\_\_\_\_

**FINANCIALLY RESPONSIBLE PERSON**

Insured's Name: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
(Address) (City) (State) (Zip)

Home Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M F Marital Status: S M D Other \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Status: Full Time Part Time

Work Address: \_\_\_\_\_  
(Address) (City) (State) (Zip)

**INSURANCE INFORMATION**

Insurance Coverage?: \_\_\_ Y \_\_\_ N Copay?: \_\_\_ Y \_\_\_ N If so, amount? \$ \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Address of Insurance: \_\_\_\_\_  
(Address) (City) (State) (Zip)

Phone Number: \_\_\_\_\_ ID# \_\_\_\_\_

Group Name: \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber's relation to patient: Self Spouse Parent Other \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Secondary Address: \_\_\_\_\_  
(Address) (City) (State) (Zip)

Secondary Phone: \_\_\_\_\_ ID# \_\_\_\_\_

Group Name: \_\_\_\_\_ Group # \_\_\_\_\_

I understand that I am responsible for my entire bill. In the event of litigation, the parties agree that the prevailing party shall be entitled to reasonable court and attorney's fees.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby authorize the release of any medical or other information necessary to process all claims. I also authorize payment of medical benefits to the provider for services rendered. I further agree that should the amount be insufficient to cover the entire expense, I will be responsible to the provider for payment of the entire bill.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_