Big Apple Speech Therapy, LLC

INTAKE FORM

Diagnosis: _____
(for office use only)

Date: _____

PATIENT INFORMATION

Patient Name: _____ Email: _____

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: _____

PCP Name & Number: _____

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: _____