
Speech Therapy



Center of Excellence

5516 SOUTH FORT APACHE ROAD, SUITE 130

LAS VEGAS, NEVADA 89148

Tel. (702)641-8255 (TALK) * Fax (702)399-8255 (TALK)

website: speechtherapycenterlv.com

Jil M. Gertz, M.A./CCC-SLP Shelley Paulson, M.S./CCC-SLP

ASHA Certified, Nevada Licensed Speech Language Pathologists

MEDICAL INFORMATION RELEASE FORM

(HIPAA RELEASE FORM)

Name: _____ Date of Birth: _____

RELEASE OF INFORMATION

[] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[] Spouse _____

[] Child(ren) _____

[] Other _____

[] Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Signed: _____ Date: _____

Witness: _____ Date: _____

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Shelley Paulson, MS/CCC-SLP

Jill M. Gertz, MA/CCC-SLP

Speech Therapy Center of Excellence is devoted to the care and treatment of our patients. Our therapists create a unique and specific treatment plan for each of their patients. Preparation time is used to select specific tools and materials for individualized sessions. When a patient does not show for an appointment or give sufficient notice to cancel an appointment, the treatment plan is disrupted and we lose the opportunity to accommodate an alternate patient. Please respect our therapists' time and efforts on your behalf.

NO-SHOW/LATE CANCELLATION CHARGE POLICY

A cancellation is considered late when call is received with less than a 24 hour notice. All no-shows and late cancellations are subject to a charge of \$50.00 for the missed appointment. It is further understood that this fee is not a billable charge for insurance purposes and that it is the patient/guarantor's responsibility for payment of the no-show/late cancellation charge.

Charges will be implemented as follows:

- The first no-show/late cancellation charge of \$50.00 will be due on or before the next appointment.
- The second no-show/late cancellation charge will be due on or before the next appointment and patient will be removed from the recurrent schedule. Subsequent appointments may be made on an "as available" basis.
- Excessive cancellations and inconsistent attendance may result in removal from schedule. This is necessary because we have patients on a waiting list who are waiting for a schedule.

***All parents must remain in the office while child is being treated.**

I have read and understand the above No-Show/Late Cancellation Policy:

Print Name

Patient / Guardian Signature

Date

Speech Therapy Center of Excellence

Patient Registration Form

Referring Physicians Information					
Referred By:			Phone:		
Address:			Fax:		
Patients Information					
Full Legal Name:			SSN:		
Address			City/State/Zip:		
Home Phone	Cell Phone	Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth	Age:	Marital Status:
Email Address:		Emergency Contact Person:		Emergency Contact Phone:	
If Patient is a minor fill-out below:					
Mother's Name:			Father's name:		
Mother SSN:	Mother Date of Birth:	Father SSN:	Father Date of Birth:		
Mother's Work Phone:			Father's Work Phone:		
If Married Spouse's Information:					
Spouse's Name:			Spouse's Phone:		
Address (if different):			City/State/Zip:		
Primary Insurance Information					
Company:			Phone:		
Address:			City/State/Zip		
Insured:			Relationship:		
Policy Number:			Group Number:		
Secondary Insurance Information					
Company:			Phone:		
Address:			City/State/Zip		
Insured:			Relationship:		
Policy Number:			Group Number:		

I authorize **Speech Therapy Center of Excellence, Inc.** and/or their billing service to bill my insurance for any/all services rendered on the person listed above. I also allow my insurance to send payments directly to **Speech Therapy Center of Excellence, Inc.** I understand that I am responsible for any co-pays, co-insurance and /or deductibles not covered by my insurance at the time services are rendered. Should insurance coverage terminate prior to or during the time the patient is receiving services, the patient will be liable for the entire billed amount of those services. Patient is solely responsible for notifying the office of any insurance changes, additions or deletions. Insurance is billed as a courtesy; the patient is financially responsible for all unpaid balances.

If for any reason a collection agency is required to collect outstanding funds, I understand that I am responsible for collection fees as well.

The information stated above, to the best of my knowledge, is correct and complete:

Signature

Print Name

Relationship

Date