NEW PATIENT PAPERWORK

MEDICAL INFORMATION RELEASE FORM (HIPAA RELEASE FORM)

SPEECH THERAPY CENTER OF EXCELLENCE

5516 South Fort Apache Road, Suite 130
Las Vegas, Nevada 89148
Tel. (702)641-8255
Fax (702)399-8255
speechtherapycenterlv.com

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.

Signature_____Date_____

Witness_____Date_____

Patient name_____

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 will be due on or before the next appointment.
- The second no-show/late cancellation charge will be due upon occurrence; patient will be discharged and the referring physician will be notified.

TARDINESS POLICY

If you arrive 10 minutes late for your scheduled appointment your therapist will see you for a shortened session. Should your arrival time be beyond 10 minutes late, you will not be seen. The appointment will be cancelled and rescheduled if possible. Two late arrivals will result in discharge and the referring physician will be notified.

YOUR INSURANCE IS ULTIMATELY YOUR RESPONSIBILITY

Please review the following:

- Double check with your insurance company to determine if AUTHORIZATION is required for your visits.
- Please note authorization is not a guarantee of payment. Benefits are reviewed at the time the claim is submitted.
- If your visit is denied for ANY REASON, you will be billed for the services
- We are NOT responsible for checking your benefits; this is a courtesy and we cannot guarantee any information we receive from the insurance company.

NOTE: ALL PARENTS MUST REMAIN IN THE OFFICE WHILE CHILD IS BEING TREATED. I have read and understand the above policies:

Signature_____Date_____

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 ☐ Female ☐	Date of Birth	Age	Martial 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