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 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