PATIENT REGISTRATION FORM

Patient Last Name	**First Name**	**Date of Birth**	**Gender**	**Best phone/text number**

Address	**Apt/Unit**	**City**	**State**	**Zip Code**

E-mail Address

Parent/Spouse Name	**Phone Number**

Other Caregiver/Parent/Spouse Name	**Phone Number**

Emergency Contact Name	**Phone Number**

Primary Insurance	**Policy Number**	**Group #**

Insured Name	**Date of Birth**

Insurance Provider Phone Number	Insurance Auth Phone #

Insurance Claim Fax Number	Insurance Auth Fax Number

Deductible _$__________ Co-Pay $_________ Need Card on File? Y or N

Need Auth? Y or N Name Card on File is Under: ____________________ Square or Stripe

Referring Physician	**Name of Clinic**

Physician Phone Number	Physician Fax Number	NPI

List any/all people that you are permitting Talk to Me Speech Therapy to discuss and/or view your medical treatment with and their relationship to you. If no name listed, information will only be discussed with the patient's guardian/parent.

PATIENT REGISTRATION FORM

Secondary Insurance	**Policy Number**	**Group #**

Insured Name	**Date of Birth**
Insurance Provider Phone Number	Insurance Auth Phone #
Insurance Claim Fax Number	Insurance Auth Fax Number

Deductible _$__________ Co-Pay $________ Need Auth? Y or N

The information stated above, to the best of my knowledge is correct and complete. I authorize Talk to Me Speech Therapy 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 Talk to Me Speech Therapy. I understand that I am responsible for any co-payments and/or deductibles not covered by my insurance. If for any reason a collection agency is required to collect outstanding funds, I understand that I am responsible for collection fees as well. I authorize Talk to Me Speech Therapy to release all necessary information to my insurance company. The below signature releases any/all medical records past or present to Talk to Me Speech Therapy from other providers.

____ ____________________

Parent/Guardian/Patient Signature Date