Patient Registration Form

Patient's/ Child's Full Name: ______________________________ Date of Birth: ______________

Diagnosis and Concerns: ____

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Father's Name: ____

Mother's Name: ____

Home Address: ____

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Home Phone: __________________________ Other Phone: ____________________________

Other Services: ____

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Physician's Name and Phone: ____

Medical Conditions and Allergies: ____

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INSURANCE/BILLING INFORMATION

Insured's Full Name: __________________________ ID #: ___________________ _______

Insured's Birth Date: ________________________ E Mail: ___________________________

Company: _____________________________ Group #: ______________________________

Billing Insurance Address (or Card Copy): ____

ASSIGNMENT AND RELEASE: I understand that I am financially responsible for payment to Darcy Kelley for services provided and that it is my responsibility to determine insurance coverage. Payment is due at the time of service unless other arrangements have been made with my insurance company. I authorize medical benefits to be paid directly to the certified speech pathologist or associates named above. I authorize Darcy Kelley to release necessary information needed to process this claim directly to my insurance company.

Signature____ **Date** ______________________