PATIENT REGISTRATION
AND
INSURANCE VERIFICATION

Today's Date: _____

Policy Owner's Name:_____ Date of Birth of Policy Owner: _____

Address: _____

City, State, ZIP: _____

Best Contact Phone: _____ Email Address: _____

Employer: _____

Child's Name: _____ Date of Birth: _____

Relationship to Child: _____ Spouse:
_____

Primary Insurance Information

Insurance Company: _____

Insurance Company Address: _____

City, State, ZIP: _____

Insurance Phone: _____

Group Number: _____ Identification Number: _____

Pediatrician: _____ Phone: _____

Pediatrician Address: _____

City, State, ZIP: _____

Assignment and Release

I understand that I am financially responsible for payment to Clear Speech, Incorporated for the charges not covered by my insurance company. I authorize medical benefits be paid directly to Clear Speech, Incorporated. I also authorize my therapist and/or insurance company to release any information required for claims related to therapy services. I understand that any unpaid balance over 60 days is subject to being turned over to a collections agency that represents Clear Speech, Incorporated.

Signature: _____ Date: _____

Official Use Only:

Primary Insurance: Spoke with _____ Date _____
Is there a Neurodevelopmental speech Benefit? Yes No Is there a Rehab speech Benefit? Yes No
Is a Referral required? Yes No Is an authorization required? Yes No
How is authorization obtained? _____
How many visits per year? _____ Is there a dollar limit? What is it: _____
What is the max benefit for speech therapy per year _____ Copay _____ Co insur ___
What is the deductible? _____ Has deductible been met for this year? Yes No
Any Exclusion clauses? _____
Notes:

Secondary Insurance: Spoke with _____ Date _____
Is there a Neurodevelopmental speech Benefit? Yes No Is there a Rehab speech Benefit? Yes No
Is a Referral required? Yes No Is an authorization required? Yes No
How is authorization obtained? _____
How many visits per year? _____ Is there a dollar limit? What is it: _____
What is the max benefit for speech therapy per year _____ Copay _____ Co insur ___
What is the deductible? _____ Has deductible been met for this year? Yes No
Any Exclusion clauses? _____
Notes: