☐ Diane Hansen, MA, CCC-SLP ☐ Christine Butalla, MS, CCC-SLP
☐ Hannah Irving, MS, CCC-SLP ☐ Nicole Allen, MS, CCC-SLP
☐ Whitney de Haseth, MS, CCC-SLP ☐

Patient Information:

Patient Name
Birthdate / / Age Sex: ☐ Male ☐ Female
Address Apt
City State Zip
Home Phone ( ) - Cell Phone ( ) -
Email
Relationship to Patient

Emergency Contact
Relationship to Patient
Phone Number( ) -

Referring Physician
Phone Number( ) -
Primary Care Physician
Phone Number( ) -

Government Required Questions:

Race: ☐ Caucasian, ☐ Asian, ☐ African American, ☐ American Indian/Alaska Native, ☐ Native Hawaiian/Pacific Islander, ☐ Other (Please specify)

Language: ☐ English, ☐ Spanish, ☐ Other (Please specify)

Ethnicity: ☐ Hispanic/Latino, ☐ Non Hispanic/Latino

Religion: , ☐ None

☐ **Refuse to answer the above government requirements**

Insurance Information:

Primary Insurance Company
Identification Number Group Number
Name of Policy Holder
Birthdate / / Marital Status: ☐ M, ☐ S, ☐ D, ☐ W
Phone Number( ) - Social Security Number
Employer

Secondary Insurance Company (if applicable)
Identification Number Group Number
Name of Policy Holder
Birthdate / / Marital Status: ☐ M, ☐ S, ☐ D, ☐ W
Phone Number( ) - Social Security Number
Employer

Specific Information Release (doctors, other family members, other specialists):
I specifically authorize Speech Center of Southern Arizona to release any medical and/or billing information to the following individuals:

Name

Relationship to Patient

Address Apt

City State Zip Phone Number ( ) -

Financially Responsible Party:

If you are providing the information above for a patient under the age of 18 yrs, please complete section below:

Parent One: Full Legal Name

Social Security Number Birthdate / /

Relationship to Patient

Address(If different than above) Apt

City State Zip Phone Number ( ) -

Parent Two: Full Legal Name

Social Security Number Birthdate / /

Relationship to Patient

Address (If different than above) Apt

City State Zip Phone Number ( ) -

PATIENT ACKNOWLEDGEMENT OF: FINANCIAL RESPONSIBILITY, NO SHOW FEES AND CONSENT TO TREAT:

Financial Responsibility Policy: SCOSA is contracted with many insurance plans, some of which require referrals and/or authorizations. It is your responsibility to ensure the correct referral and/or authorization is in place. It is also your responsibility to provide all current insurance carrier information (including AHCCCS plans). You understand that you may be responsible for fees associated with services rendered if you are not eligible for AHCCCS, have not secured the appropriate referral and/or authorization, or the services provided are a non-covered benefit of your insurance provider. You authorize all insurance benefits be paid directly to SCOSA. You acknowledge that SCOSA will charge a $35.00 fee for each non-sufficient check. You authorize the release of medical information for processing these claims.

You understand and agree that, as a patient and/or guarantor that in consideration of the services to be rendered, that you obligate yourself to pay the account of the medical office in accordance with the regular rates, terms and interest (18% interest per annum on accounts 30 days past due) on any unpaid balance identified by SCOSA. In the event that it is necessary to place the account with a collections agency to collect the balance due, an additional 35% of the principal balance due will be added. In addition, should legal action become necessary to collect a balance due, you understand that you will be responsible for payment of attorneyâs fees, interests and court costs. You also understand that if your account is placed with an agency for collection or placed with an attorney for legal action that a credit report may be pulled for the sole purpose of collecting the delinquent account.

No Show Policy: You will be charged a fee of $45.00 for any appointment that you miss for which you have not provided at least 24-hours advanced notice of cancellation. If you need to cancel or reschedule an appointment, please call SCOSA at least 24-hours prior to your scheduled appointment. Exceptions will be made for emergencies.

Consent to Treat: You consent to speech therapy treatment (the Treatment), which will be rendered by SCOSA providers (the Provider(s)). You will have the opportunity to discuss the Treatment with your Provider(s), at which time you will have the opportunity to discuss the risks and benefits of the Treatment. You will have the opportunity to ask questions about the Treatment. You may revoke your consent to this Treatment at any time.

As the legal guardian of the patient, I agree to all of the above and consent for Speech Center to provide treatment:

Signature **Date** / /

Printed Name of Parent