PATIENT REGISTRATION FORM - SPEECH CENTER OF SOUTHERN ARIZONA

____Diane Hansen, MA, CCC-SLP
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____ Kathe McGrath MS, CCC-SLP
____ Jeannine Miller MS, CCC-SLP

PATIENT INFORMATION:

PATIENT_____ BIRTHDATE ____/____/____ AGE _____
Last First Middle
ADDRESS_____Apt# _____ HOME #(_____) _____-_____

CITY_____STATE_____ZIP_____CELL#(____)_____-_____ RELATION TO PATIENT_____

SOCIAL SECURITY#_____-_____-_____ SEX: Male ☐ Female ☐ MARITAL STATUS: M S D W

PREFERRED CONTACT: CELL PH ☐ HOME PH ☐ E-MAIL☐ _____

EMERGENCY CONTACT INFORMATION:
NAME_____RELATIONSHIP_____PHONE#(_____) _____-_____

PRIMARY CARE PHYSICIAN_____PHONE# (_____) _____- _____

REFERRING PHYSICIAN_____PHONE# (_____)_____- _____

THE GOVERNMENT REQUIRES US TO ASK THESE QUESTIONS BELOW

RACE: Caucasian ☐ Asian ☐ African American ☐ American Indian/Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐
LANGUAGE: English☐ Spanish☐ French☐ German☐ Italian ☐ Mandarin☐ Vietnamese☐ Russian☐
ETHNICITY: Hispanic or Latino☐ Non Hispanic or Latino☐
RELIGION:_____ NONE: ☐
REFUSE TO ANSWER THE ABOVE GOVERNMENT REQUIREMENTS: ☐

INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY:_____ ID#_____GROUP#_____

POLICY HOLDER NAME:_____BIRTH DATE:____/____/____ MARITAL STATUS: M S D W

EMPLOYER_____PHONE#(____)_____SS# _____ - ____ - _____

ADDRESS_____CITY_____ STATE_____ ZIP +4_____

SECONDARY INSURANCE CO:_____ID#_____GROUP#_____

POLICY HOLDERS NAME:_____BIRTH DATE:____/____/____SS#_____- ____ - _____

SPECIFIC INFORMATION RELEASE (Doctors, other family members, other specialists):

I specifically authorize Speech Center of So Az to release any medical and/or billing information to the following individuals:

NAME_____RELATIONSHIP TO PATIENT _____
PHONE# (_____)_____-_____ ADDRESS _____CITY_____STATE____ZIP_____

SIGNATURE_____ PRINTED NAME_____
DATE_____ RELATIONSHIP TO PATIENT _____

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FINANCIALLY RESPONSIBLE PARTY:

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

FULL LEGAL NAME:_____ SOCIAL SECURITY #_____-_____-_____

Date of Birth_____/_____/_____ Phone: (_____)_____- _____Relationship to Patient:_____

EMPLOYER_____PHONE # (____)_____

Address (if different from above):_____City_____ State_____Zip _____

PATIENT ACKNOWLEDGEMENT OF: WELLNESS PROGRAM, NOTICE OF PRIVACY PRACTICES (HIPAA), FINANCIAL RESPONSIBILITY, NO SHOW FEES AND RELEASE OF INFORMATION:

Diane Hansen keeps medically safe science based wellness supplement supplies in the office for your convenience. I want you to know that because of my belief in the integrity and effectiveness of these supplements, I distribute the products and may receive commissions from your purchases. Of course you may find products else where. In response to our patients' requests we also provide you access to a web portal, www.nutrametrix/dhansen, where you will find education, science, and doctor-approved natural branded health formulas available only through licensed health professionals. Children who arrive for their visit at their optimal health have greater potential to benefit from our care. Diane Hansen will be happy to talk to your primary care physician, however you must inform your primary care physician of everything you are taking to ensure safety and avoid contraindications with medications.

Speech Center of Southern Arizona is contracted with many insurance plans, some of which require appropriate referrals and/or authorizations. Obtaining the referral and/or authorization is the patient's responsibility. It is also your responsibility to provide all current insurance carrier information including AHCCCS plans. I understand that I am responsible for any changes incurred if I am not eligible, have not secured the appropriate referral and/or authorization, or the services provided are a non-covered benefit. I authorize that all insurance benefits be paid directly to Speech Center of Southern Arizona. Speech Center of Southern Arizona will charge a $35.00 fee for all non-sufficient checks. More than one NSF check will be turned over to the "BAD CHECK PROGRAM". Additional fees will be added. I authorize the release of medical information for processing my claims.

The following is our "NO SHOW" policy. A "NO SHOW" is when you do not provide 24 hour cancellation notice for your office appointment with Speech Center of Southern Arizona. The "NO SHOW" fee your office appointment is $45.00

COLLECTION / ATTORNEY FEES:
If this account is referred for collections, I/we agree to pay collection fess up to (35%) on the balance owing. If legal action is deemed necessary, I/we agree to pay reasonable attorney's fees and court costs in addition to the above costs.

SIGNATURE_____ **DATE**_____

Printed Name of Patient_____