Aspen speech therapy

Creating Confidence That Lasts A Lifetime

Date:______/_______/_______

Patient Information		
Name:		
Social Security:	**Date of Birth:**	**Sex: Male Female**
Address:		
Home Phone:	**Cell Phone:**	**Work Phone:**
Email:		
Doctor's Name:		

Insurance Information	
Name of Insurance:	
Name of Insured:	**Date of Birth of Insured:**
Relationship to Patient:	

Guarantor Information		
Parent/Guarantor/Responsible Party Name:		
Address:		
Home Phone:	**Cell Phone:**	**Work Phone:**
Email:		

*Patients are responsible for payment of copay and coinsurance before each visit

Authorization to pay Benefits to Speech Therapist

I directly assign all insurance benefits, if any, to Aspen Speech Therapy for services rendered to the patient.

Authorization of Financial Responsibility

I agree to accept personal responsibility for all medical expenses incurred and shall be responsible for the full amounts of any bill or portions thereof which my insurance company does not pay.

I have read the above information and understand that I am responsible for payment of the services I receive.

______________________________________ ________/________/________

Signature of Patient/Guardian/Responsible Party Date