Patient Processsed ______
Insurance Contacted______
Disorder Type ________

ACE Speech and Language Clinic, LLC
Patient Information Form

Patient Information

Last Name	
First Name	
Middle Initial	
Street Address	
City	State Zip
Phone Number	H( ) W( )
Date Of Birth	
Sex	M F

Responsible Party or Insured (Enter Same if Patient)

Last Name ______________________
First Name ______________________
Middle Initial ______________________
Street Address ______________________
City State Zip ______________________
Phone Number H( ) W( ) ______________________
Date of Birth ______________________
Employer Name ______________________
Employer Address

Insurance Information

Insurance Company Name ______________________
Insured Policy Number ______________________
Insured ID Number

Referring Physician Name and Clinic Address

Name ______________________
Clinic Name ______________________
Street Address ______________________
City State Zip ______________________
Phone Number

Over Please

Cancellation Policy:

ACE Speech and Language Clinic, LLC requires advanced notice of all appointment cancellations. This allows us to meet the scheduling needs of all of our patients. If an appointment is not cancelled in advance, you will be assessed a charge of $25.00. Your insurance company will not cover this charge, it is your responsibility.

__________ Initials of responsible party acknowledging Cancellation Policy.

Billing Policy:

Insurance co-payments are due at the time of service.
If you are a client without insurance, a billing discount will be given if payment is received at the time of service by cash or check. This discount does not apply towards insurance co-payments.
A 5% late fee will be applied to all patient balances over 60 days old from the date of your patient statement.

_______Initials of responsible party acknowledging Billing Policy

Assignment of Benefits:

I hereby authorize payment of benefits to ACE Speech and Language Clinic, LLC, for services rendered to myself and/or dependents. I understand and agree that I will be financially responsible for the charges that I incur with ACE Speech and Language Clinic, LLC, that are not paid by insurance.

Signature:________________________________ Date:_________________

Referral Obligation

I acknowledge that I am seeing my speech and language pathologist without a referral from my insurance company or primary care physician. I understand and agree that if one is necessary, I will obtain that referral.

Signature:________________________________ Date:_________________