Speech & Language Stimulation Center, Inc.
Ann L. Pendley, Ph.D., CCC-SLP & Associates

317 North Meldrum
Fort Collins, Colorado 80521
slsc@frii.com
970.495.1150 Fax: 495-0133

Child's Name_____ Today's Date:_____

Address:_____
Street City State Zip Code

Date of Birth:_____ Phone number:(____)_____

Age:_____ Social Security #:_____

Client's Primary Physician:_____

Is child allergic to anything (pets, foods)?:_____

Any other critical information we should know?_____

Parent 1:_____
Check here if address is same as child's address listed above: ____ (if different write below)

Address:_____ Home:(_____)_____

Fax/Email:_____ cell:(____)_____ Work:(____)_____

Employer:_____ Occupation:_____

Parent 2:_____
Check here if address is same as child's address listed above: ____ (if different write below)

Address:_____ Home:(_____)_____

Fax/Email:_____ cell:(____)_____ Work:(____)_____

Employer:_____ Occupation:_____

Who is responsible for Payment:_____

Who referred you to our clinic?:_____

Emergency Contact:_____
Name Phone number

INSURANCE INFORMATION:
Do you have health insurance? YES NO (circle one)
Who's your Primary Insurance:_____

OFFICE ONLY: ☐ Copy of Insurance Card taken

Secondary Insurance:_____

FEE POLICY:
Payment is due at time of service. Insurance is for the purpose of reimbursing the patient. We will gladly help you complete insurance forms although this fee contract is directly with you. Total fees for evaluations and therapy vary depending on time involved. **A session includes 5-10 minutes of chart writing and preparation time. We will bill for appointments canceled less than 24 hours in advance (unless emergency occurs).** You will be billed for any charges through our bookkeeping office. An interest fee of 1.5% will be charged for balances more than 30 days old. You will be given more specific information in writing about these policies.

CONSENT FOR TREATMENT AND UNDERTAKING TO PAY FEES:
I authorize Dr. Ann Pendley, Associates or Subcontractors at the Speech & Language Stimulation Center, Inc. to perform speech-language diagnostic evaluations and treatments as appropriate and necessary; I agree to pay all of the charges for such procedures upon receipt of the statement. I agree to allow Dr. Pendley & Associates to release my billing information (including diagnoses) to a third party for purposes of collection, and agree to pay all costs of collection including reasonable attorneys' fees if applicable.

_____ _____
SIGNATURE OF RESPONSIBLE PARTY DATE