



Child Intake Sheet

Child's Name Today's Date:
Address: Street City State Zip Code
Date of Birth: Phone number:()
Age: Social Security #: only upon request
Client's Primary Physician: Address:
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 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 Speech & Language Stimulation Center, Inc. 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