

CLIENT INFORMATION FORM for *Speech Therapy*

NAME _____ AGE _____ BIRTHDATE _____ SEX _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PROFESSION _____ Home Phone# _____ Work/Cell# _____ Ext _____

Email Address: _____

MARITAL STATUS: S M W D Sep. Spouse's Name _____

YOUR SOC. SEC.# _____ - _____ - _____ SPOUSE'S SOC. SEC.# _____ - _____ - _____

HOW did you hear about our services? _____

INSURANCE INFORMATION:

InsuranceCo.Name _____ Phone _____

Ins.Co.Address _____ Zip _____

Policy# _____ Group# _____ Plan# _____

Insured's Name _____ Ins.Claims-person _____

Insured's Employer _____

DO YOU HAVE SECONDARY INSURANCE? []YES []NO If yes, please complete the following:

Second Ins.Co.Name _____ Phone _____ Ext. _____

Ins.Co.Address _____ Zip _____

Policy# _____ Group# _____ Plan# _____

Insured's Name _____ Ins.Claims-person _____

Insured's Employer _____

DOCTORS' NAMES(1) _____ (2) _____

Addresses _____

Phone# _____ Phone# _____

WHAT ARE YOU SEEKING TREATMENT FOR? (Please circle all that apply)

SPEECH VOICE SWALLOWING COGNITION APHASIA

Date symptoms started: _____ Onset of symptoms: (circle) GRADUAL or SUDDEN

PLEASE GIVE NAMES OF ANY OTHER HEALTH CARE PROFESSIONALS HAVE RECENTLY OR ARE CURRENTLY SEEING (Physical therapist, occupational therapist, speech therapist, psychologist, etc.):

RESPONSIBLE PARTY (who will be responsible for paying the bill?)

Name _____ Relationship To You _____

Address _____ Zip _____

HomePhone# _____ WorkPhone# _____ Ext _____

I understand that each visit is to be paid for at the time of the visit, unless prior arrangements have been made. I also understand that no one will be denied medical care if they do not have sufficient funds at the time of the visit. However, payment for such visits is expected to be fulfilled within 30 (thirty) days of the visit. A late fee may be charged on overdue account balances.

I understand that I will be charged for an appointment which I miss and do not cancel before 8AM of the day PREVIOUS to my scheduled appointment.

I have read the two statements above, and I understand them. I hereby consent to treatment by Backway's Physical Therapy, PLLC.

Signed _____ Date _____

***** (FOR OFFICE USE ONLY) Special Billing Arrangements/Deductible/ETC. _____