SPEECH and LANGUAGE THERAPY SERVICES, LLC
1016 2nd Ave N. North Myrtle Beach SC 29582
Office (843) 491-3572 Fax (843) 491-3573
speechtherapy.nmb@gmail.com

Referred By: _____

Date: _____

Patient's name: _____ Age: _____

Date of Birth: _____ Male: _____ Female: _____

Parent's name: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Cell Phone Number: _____

Email Address: _____

_____Please check if you would like to receive emails regarding cancellation of therapy as well as copies of evaluations, progress notes, and re-evaluations.

Insurance: _____ Subscriber Name: _____

Subscriber DOB: _____ Relationship to patient: _____

ID Number: _____

Family Physician: _____ Phone Number: _____

By signing this form I give my consent for the following:

- Evaluation and treatment of speech language pathology services as needed
- Release of any information requested by my insurance carrier

Sign Name: _____
Print Name: _____
Date: _____