# PATIENT REGISTRATION FORM
# PRINT OR FAX TO: 603-893-8680

## Patient Information

Date ____________________

| | |
|---|---|
| Name ____________________ | Home Number ____________________ |
| Address ____________________ | Cell Number ____________________ |
| City __________ State ____ Zip Code __________ | Email ____________________ |
| Country ____________________ | Sex ____________________ |
| Date of Birth ____________________ | Marital Status ____________________ |

## Insurance Information

**Primary Insurance Carrier** ____________________

| | |
|---|---|
| Member Id# ____________________ | Effective Date ____________________ |
| Subscriber ____________________ | Subscriber Date of Birth ____________________ |
| Subscriber SS# ____________________ | Relationship to Patient ____________________ |
| Subscriber Employer ____________________ | Tel Number ____________________ |

**Secondary Insurance Carrier** ____________________

| | |
|---|---|
| Member Id# ____________________ | Effective Date ____________________ |
| Subscriber ____________________ | Subscriber Date of Birth ____________________ |
| Subscriber SS# ____________________ | Relationship to Patient ____________________ |
| Subscriber Employer ____________________ | Tel Number ____________________ |

By my signature below, I authorize Speech Therapy Solutions, Inc. to submit claims to my insurance carrier and accept that all unpaid balances will be the responsibility of the undersigned. This includes fees associated with the collection of balances (e.g. Collection agency fees, attorney and court fees, etc.). I authorize the release of any medical information necessary to process the claim. I also herby authorize the release and assign benefits otherwise paybale to the practice. I understand that referral authorization for evaluation and/or therapy visits is the responsibility of the patient or responsible party.

I further acknowledge that I have been offered the privacy notice for this practice.

____________________________________________ Date ____________________

Signed By

____________________________________________

Referred By