SPEECH THERAPY ASSOCIATES

501 S. Rancho Suite I-60 Las Vegas, NV 89106
(P) 598-1622 (F) 598-1696

Patient Information **PLEASE PRINT** SSN:_____

Full Name: _____ Date of Birth: _____

Address: _____ Apt/Space/Unit: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone:_____

Email Address: _____Referred By: _____

Emergency Contact: _____ Phone: _____ Relation:_____

Parent/Guardian/Spouse Information SSN:_____

Full Name: _____ Date of Birth: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

******* INSURANCE INFORMATION *******

Primary Insurance Company: _____ Phone: _____

Policyholder's Name: _____ Policyholder's DOB: _____

Policyholder's SSN: _____ ID#: _____ Group#: _____

Insurance Address: _____

Employer: _____ Work Phone: _____ ext: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other: _____

Secondary Insurance Company: _____ Phone: _____

Policyholder's Name: _____ Policyholder's DOB: _____

Policyholder's SSN: _____ ID#: _____ Group#: _____

Insurance Address: _____

Employer: _____ Work Phone: _____ ext: _____
Relationship to Patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other: _____

PLEASE READ THE FOLLOWING CAREFULLY:

All deductible, co-payments and applicable charges will be due at the time of service-**NO EXCEPTIONS**. I hereby authorize release of information necessary to file a claim with my insurance company. The above information is complete and correct. I assign benefits otherwise payable to me, to Speech Therapy Associates. All professional services rendered are charged to the patient. **The patient is responsible for all fees regardless of insurance coverage.** In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover money due.

Patient/Legal Guardian Signature: _____ Date: _____