Speech Inspiration, PLLC

Original Date:	2013
Dates Revised:	

PATIENT REGISTRATION
PATIENT AUTHORIZATION AND IRREVOCABLE ASSIGNMENTS

Information on this form is considered confidential.

PATIENT			
Name *(First, Middle, Last)*		☐ **M** ☐ **F**	**DOB:**
Address *(Street, City, Zip):*			
Email:			
Home Phone:	**Work Phone:**	**Cell Phone:**	**Fax:**
Social Security #:	**Driver's License #** (number & state)**::**		

PAYMENT RESPONSIBILITY (GUARANTOR)		
Person Responsible for Payment:		
Address*(Street, City, Zip)***:**		
Relationship to Patient*:*	**Email:**	
Phone (Office):	**Mobile:**	**Work:**
Employer:	**Work Status: ___Full Time ___Part Time ___Retire ___Unemployed**	
Social Security #:	**Driver's License # (**number & state**):**	**DOB:**

INSURANCE PLAN 1	
Insurance Company:	
Group #:	**Subscriber#:**
Name of Insured:	**DOB:**
Employer of Insured:	**Work Phone:**
Work Status: ___Full Time ___Part Time ___Retire ___Unemployed	**Cell Phone:**

INSURANCE PLAN 2	
Insurance Company:	
Group #:	**Subscriber #:**

Name of Insured:	**DOB:**
Employer of Insured:	**Work Phone:**
Work Status: ___Full Time ___Part Time ___Retire ___Unemployed	**Cell Phone:**

AUTHORIZATION AND IRREVOCABLE ASSIGNMENT

1. I understand that the Authorizations and Revocable Assignments contained in this document apply to all treatments provided by Speech Inspiration, PLLC.
2. **I agree to be responsible for the payment of all charges that result from the care provided to the patient. I also understand that I may be responsible to pay for services that are not covered by my plan, and in some circumstances, for services that are covered by my plan. I understand that this means that I promise to pay Speech Inspiration, PLLC in return for the care and services that will be provided to the patient.**
3. I hereby irrevocably assign and transfer to Speech Inspiration, PLLC all rights, title and interest in any benefits payable in all causes of action against all insurance companies, employee benefit plans, their party administrators and/or other persons or entities responsible for the payment of benefits ("Responsible Parties") for all treatment provided by Speech Inspiration, PLLC, and I hereby appoint Speech Inspiration, PLLC as my attorney in fact, with power of substitution to sue or otherwise obtain payment of benefits from the Responsible Parties. This irrevocable assignment and transfer shall be for the purpose of granting Speech Inspiration, PLLC an independent legal right of recovery against such Responsible Parties, but shall not be construed to be an obligation of Speech Inspiration, PLLC to pursue any such right of recovery.
4. I understand that if the patient's insurance requires pre-authorization for services, it is my responsibility to notify the appropriate certification area. I understand that if the pre-authorization is not obtained, a penalty can be applied by the insurance company causing a reduction in the patient benefits.
5. Pursuant to federal and state law, the undersigned consents to the use and disclosure by Speech Inspiration, PLLC of the patient's record, to any person or entity that is or may be responsible for all or any portion of Speech Inspiration, PLLC's charges, including but not limited to insurance companies, health care service plans, workers compensation carriers, medical or utilization review organizations of the foregoing, or to any other person or entity as necessary in connection with such payments or reimbursement. The undersigned also agrees that Speech Inspiration, PLLC may obtain from any source and examine and use, or discuss and disclose, the patient's speech and language record and information (including history, evaluations, diagnoses, treatments) to treating professionals and agents, other healthcare providers, medical record auditors, professional committees, care evaluators and governmental agencies in order to treat the patient or for Speech Inspiration, PLLC to carry out its operational duties. This consent to release and obtain information is valid until revoked, and the undersigned may revoke consent in writing at any time, except with regard to disclosures that have already been made in reliance on such consent.

Please sign to indicate your agreement below.

Signature of Patient/Parent/Guardian:_____Date:_____

Printed Name of Patient/Parent/Guardian:_____

Relationship to Patient:_____

Patient is: ___a minor _____unable to sign