

Communication Matters

Speech-Language Pathology

A Professional Corporation

"Enhancing Lives Through Communication"



Registration

Patient Name: _____ Age: _____ Birth date: _____ M ___ F ___

Name of Parents/Spouse/Guardian: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Patient's Cell Phone: _____

Mom Cell: _____ Dad Cell: _____ Email address: _____

Patient's Physician: _____ Physician Phone: _____

Payment Plan selected:

Time of service Monthly Prepay Regional Center Other: _____

As the responsible party or patient I hereby authorize you to bill my funding agency. I authorize you to bill on my behalf with payments made directly to Communication Matters. I also authorize the release of any and all information necessary to secure the payment of benefits. **Initial:** _____

Cancellation Policy: We require 24 hours notice of cancellations. If we do not receive this notice, our policy is that we bill for the missed session. This fee cannot be billed to an insurance company or Regional Center for payment or reimbursement. "No shows" are included in this policy. After several late cancellations and/or no shows, we reserve the right to change your standing appointment, to place services on hold or discontinue services. **Initial:** _____

Signature of Responsible Party/Patient

Date

RELEASE AND/OR CONSENT:

I hereby authorize Communication Matters to render speech-language pathology services to the above-named patient. I consent to an evaluation and/or treatment sessions including any necessary testing needed for the purpose of diagnosing. I hereby consent to the release of information to Communication Matters by any hospital, extended care facility, physician, dentist, therapist, speech pathologist, audiologist, teacher, psychologist or school official. I hereby authorize Communication Matters to release information about the evaluation and/or treatment to any physician, dentist, audiologist, speech-language pathologist, therapist, educational consultant, teacher, school official, or third party payer to whom I authorize you to send a report or necessary documentation. I **consent** / **do not consent** to video/audiotaping (**circle one**).

Signature of Responsible Party/Patient

Date