

PATIENT INFORMATION

Patient Name: _____ DOB: ____/____/____
(Last) (First) (Middle Initial)

Address: _____
(Street, City, State, Zip)

Phone (____) _____ (____) _____ Social Security #: ____ - ____ - ____
(Home) (Cell)

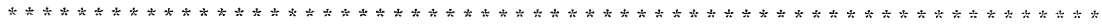
Referring Physician: _____ Phone (____) _____



MEDICAID INFORMATION

Amerigroup Superior Medicaid (please circle one)

Patient ID # _____



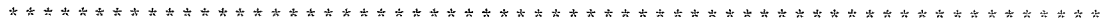
PARENT INFORMATION

Parent(s) Name: _____

Parent's Employer: _____

Employer's Address: _____

Work Phone: _____



Day care facility or school your child will be attending:

Facility Name: _____

Facility Address: _____

Facility Phone Number: _____

Director/Teacher Name(s): _____

Signature

Date

CONSENT TO TREAT AND RELEASE RECORDS
Mandatory Document for all patient charts

I, _____, hereby give consent for employees and/or representatives of Central Texas Speech Pathology Services, Inc. to share and disclose "Private Health Information" to my referring physician and Medicaid. This consent authorizes both written and verbal disclosure. This signed release shall remain valid until it is revoked, by the party signing below, in writing.

I understand that my signature on this consent form also gives my consent for treatment at this facility. Further, I acknowledge that my Medicaid information is on file with the office manager.

Central Texas Speech Pathology Services, Inc. will not disclose "Private Health Information" to any other party, agency, or organization without the express written permission of the parent/guardian signing below.

Name of referring physician: _____

Patient name: _____

Date of birth: _____

CANCELLATION POLICY

At Central Texas Speech Pathology Services Inc., we strive to ensure you the highest quality of service while maintaining cost.

When you schedule treatment, time is exclusively reserved for your child. To ensure a schedule convenient to you, the office/your therapist will discuss specific days and times for your appointments. **If you know you will miss an upcoming appointment, you must call our office 24 hours in advance (512-327-6179).** In cases of emergency, we request that you notify us as soon as possible.

If we are not notified of a cancellation, after the second consecutive occurrence, your child's therapy will be placed on hold. You must call our office (327-6179) to resolve the issue.

I have read the above and understand the cancellation policy.

Patient (or parent accompanying minor)

Date