Central Texas Speech Pathology Services, Inc.

PATIENT INFORMATION

English □ **Spanish** □

Patient Name: ______________________ ___________________ ____________ DOB: ____/____/____
(Last) (First) (Middle Initial)

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

Phone (____) __________________ ( ) ________________ **Social Security #:** ______-______-_______
(Home) (Cell)

Referring Physician: ______________________________________ **Phone (____)**_______________________

MEDICAID INFORMATION

Blue Cross **Superior** **Dell Children's Health Plan** (please circle one)

Patient ID #____

Private Insurance: **Yes** □ **No** □

PRIVATE INSURANCE INFORMATION

Insurance Company _____________________________ **HMO**______ **PPO**______

Insurance Phone ______________________ **Primary Insured** ___________________________

Primary Insured DOB: _______/_______/_______

Member ID ________________________________ **Group #** _____________________________

*****Please Attach a Copy of the Insurance Card*****

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PARENT INFORMATION

Parent(s) Name: ____

Parent's Employer: ____

Employer's Address: ____

Work Phone: ____

____ ________________________
Signature Date

Central Texas Speech Pathology Services, Inc.

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, _____, hereby give consent for employees and/or representatives of Central Texas Speech Pathology Services, Inc. to share and disclose "Private Health Information" to Child Inc. 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: _____

_____ _____
Signature Date

Central Texas Speech Pathology Services, Inc.

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