SPEAK WELL SOLUTIONS, LLC

New Client Registration Form

Yvette M. McCoy, MS CCC/SLP

Today's date:	Primary Care Provider:

CLIENT INFORMATION

Client's last name:	First:	Middle:	q Mr. q Mrs.	q Miss q Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? q Yes q No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: q M q F

Street address:	Social Security no.:	Home phone no.: ( )

E-mail:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	q Dr.	q Insurance Plan	q Hospital

q Family	q Friend	q Close to home/work	q Yellow Pages	q Other

Other family members seen here:	e-mail address:

INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a Client here?	q Yes	q No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this Client covered by insurance?	q Yes	q No

Please indicate primary insurance	q Tricare Standard	qTricare Prime	q Care First BC/BS	q Aetna	qMail Handlers

q Medicaid	q Medicare	q Cigna	q Welfare (Please provide coupon)	q Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Client's relationship to subscriber:	q Self	q Spouse	q Child	q Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Client's relationship to subscriber:	q Self	q Spouse	q Child	q Other

As a service to you the clinic will bill insurance companies and other third party payers, but cannot guarantee such benefits or the amounts covered, and is not responsible for the collection of such payments. In some cases insurance companies or third party payers may consider such services as not reasonable or necessary or may determine that services are not covered. In such cases the person responsible for payment of the account is responsible for payment of these services. We charge the usual and customary rates for the area. Funds not paid by insurance companies or third party payers must be paid with 60 days. Payments not received after 120 days are subject to collections.

OFFICE CANCELLATION POLICY

Payment is due at the time services are rendered, unless prior arrangements have been made with the provider. Twenty-four hour notice is required for appointment cancellation or the total of one office visit will be assessed. After three non-verified cancellations, the provider reserves the right to terminate therapy services, the provider also reserves the right to terminate therapy services at any time for ANY reason deemed necessary.

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to Client:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Speak Well Solutions, LLC or insurance company to release any information required to process my claims. I also understand that participation in therapy at Speak Well Solutions, LLC does not guarantee success. I have read, agree with, and understand the provisions as outlined in the above office financial and cancellation policy.

Client/Guardian signature Date

HIPPA Privacy of Information Policy

This portion describes the confidentiality of your medical records, how the information is used, your rights and how you may obtain information. The release authority applies to any information governed by the Health Insurance Portability Act of 1996, 42 USC 1320D, and CFR 160-164.

Our Legal Duties: State and Federal Law requires that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy information policy , your rights and our duties. The content of information disclosed during an evaluation, intake or treatment session are covered by the law as private information. We respect the privacy of your information and we abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information: Information about you may be used by the personnel associated with this practice for diagnosis, treatment, planning and continuity of care only. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses allied health professionals or business associates affiliated with this practice, such as billing etc. Both verbal and written records about a client cannot be shared without the written consent of the client or the client's legal guardian. Parents or legal guardians have the right to access client records.

Your Rights: You have a right to review or request your clinic files. Procedures for obtaining a copy are as follows: You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied you will receive written explanation of the denial. The charge for this service is $. 25 per page, plus postage. You have the right to know what information in your record has been provided to whom. Request this in writing. I understand the limits f confidentiality, privacy policy, my rights, their meanings and ramifications.

Client's name (please print)______________________Signature____Date:_____________________