West Side Voice & Swallowing Disorders

Amanda C Hembree MA CCC-SLP

PATIENT INFORMATION

Patient Name: _____ Soc. Sec. #: _____

Address: _____ Apt # _____ City: _____

State: _____ Zip: _____ Date of Birth: _____ Age: ____

Sex: M F Marital Status: S M D W

Home Phone: (___) _____ Work Phone: (___) _____

Cell Phone: (___) _____ E-Mail Address _____

PERSON TO CONTACT IN CASE OF EMERGENCY

Name: _____ Relationship: _____ Phone: (___) _____

EMPLOYER

Name: _____

Address: _____

PRIMARY CARE PHYSICIAN or REFERRING PHYSICIAN (to whom reports may be sent)

Name: _____ Phone: (___) _____

Address: _____

WHO REFERRED YOU TO THIS OFFICE?

□ Health Insurance Company □ Website □ Other _____

I have reviewed a copy of the Westside Voice Notice of Privacy Practice. I authorize the release of medical information necessary to communicate with the referring physician and to process the insurance claims. In accordance with medical treatment, there may be procedures or tests performed at additional cost. I authorize direct payment of covered benefits to the provider of professional services. The patient is responsible for all fees, regardless of insurance coverage. Each insurance plan is different and may not cover speech or voice therapy. It is the patient's responsibility to know his/her insurance plan's benefits. Payment for office visit is expected at the time of service. I am aware and fully understand that Ms. Hembree is a **non-participating provider for all insurance plans other than HIP and Medicare**. As a courtesy only, a claim will be forwarded to your insurance company. The patient is responsible for all unpaid claims and balance due.

I also understand that **a 24 hour notice is required for canceling or rescheduling** an appointment. I understand that if I am unable to meet this requirement; I will be charged a $75.00 canceling fee payable at my next appointment.

Date: _____ Patient Signature: _____