Dear Parents:

Thank you for inquiring about **Verbal Expressions, Inc.** We are committed to providing quality speech language therapy to children with compassion and integrity in order to ensure that your child is able to communicate with the utmost potential. We want to make sure you child reaches his/her highest potential.
Let's get started!! There are a few some very important documents that are needed in order to begin our speech therapy program. This packet of information should be brought to our office on your initial visit. There is an "Client Enrollment Packet" below that must be filled out completely. The information in the packet is necessary and essential to our comprehensive evaluation of your child. Please complete each form accurately and completely.

Before we begin our skilled speech therapy services we must have these items in for our records:
*__ORIGINAL RX__ (it is required for proper filing with insurance or Medicaid)
*Permission to Evaluate and Treat
*Client Information Sheet
*Client Medical History
*Copy of the front/back of Insurance card (if applicable)
*Copy of the front/back of Medicaid Card (if applicable)
*Financial Policy
*Release of Medical Information Form
*Signed HIPPA compliance form

Please understand that therapy WILL NOT begin without the completion of these forms.

Please contact us at (404) 297-5888 if you have any questions or concerns.
Thank You Very Much!
Verbal Expressions, Inc.

Client Information

Name: ____DOB:______________
____
Street Address: _______________________________________
City_______________________________ ___________State:
_______Zip:_______________________
Home Phone: _________________________________
Parent/Guardian Name:_________________________________Cell
Phone:_____________________
Email Address:____ Work
Phone:___________________
Referring
Pediatrician____
Address:____
Phone____
Reason for Referral:____

Insurance Information: Please check and complete all that applies along with your insurance card

____Private Pay (we accept cash, money order, credit cards or personal checks)
____Insurance Carrier ____

____HMO_____PPO________POS_____other (specify)______________
Billing
Address:____
Billing
Phone:____
Insured's
Name:____
Insured
SSN:____
Member ID#____________________________Group
#________________________
_____Babies Can't Wait (BCW)
Cost Participation: __________%
Service
Coordinator:______________________________Phone:________________
_____Medicaid (list the number
here____
______Peachstate_______Ameirgroup_____Wellcare

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