Nancy L. Foreman & Associates L.L.C.

Certified Speech-Language Pathologists
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CLIENT INFORMATION

Patient Name:_____

Address:_____

City, State, Zip:_____

Home Phone:_____Work Phone:_____Cellular:_____

Patient Date of Birth:_____Sex:_____Marital Status:_____

Patient Occupation or Grade in School:_____

Patient Name of School:_____

Patient Employer or School Address & Phone:_____

Parent or Spouse's Name:_____

Referred By: (Doctor)_____Phone #:_____

Person Responsible for Payment:_____

Insured Information

Insured's Name:_____Date of Birth:_____

Insured Address: (if different from Patient) _____

Insured's Social Security Number:_____E-mail Address:_____

Employer Name and Address:_____

Insurance Company:_____ Policy #:_____ Group #:_____

Insurance Address:_____ Insurance Phone #:_____

Do you have a Secondary Policy? Yes_____No_____

Other Insurance:_____

ATTENTION: If appointments are not cancelled at least 24 hours in advance, you will be billed $50.00 for the time reserved for you. Professional services are rendered on a cash basis. PAYMENT IS DUE, IN FULL, AT THE TIME OF SERVICE unless prior payment arrangements have been made. _____

I hereby authorize Nancy Foreman & Associates to furnish information to insurance companies concerning my illness and treatments. I hereby assign to Nancy Foreman & Associates all payments for services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance.

Clients Signature_____Date:_____

Office Use Only: Co-Pay/Co-Insurance: $_____Deductible: $_____ Allowed Visits:_____
Deductible Met: $_____
Diagnosis Code(s): _____ _____ _____ _____