Speech World, LLC
6614 Atlantic Blvd, Jacksonville, FL 32211
Phone (904) 685-4267 Fax (888) 504-5656

( ) New Patient ( ) Established Patient

Patient Name:		
Gender: Male/Female	Birthdate: / /	Social Security #:
Parent/Guardian(s):		
Marital Status: ( ) Married ( ) Single ( ) Divorced ( ) Widowed		
Street Address:		
City/State/Zip		
Home Phone:	Cell # 1:	Work # 1:
E-Mail:	Cell # 2:	Work #2:
Primary Care Physician:		
Address/Office Location		

*Please circle your primary contact number

(Please have your insurance card ready so that we may make a copy of both sides. Make sure the numbers are legible.)

Primary Insurance:	
Policyholder:	Relationship to Patient
Insurance ID:	Group #

PRIVACY

- I have received a copy of the HIPAA Privacy Regulations

AUTHORIZATION FOR TREATMENT

- I authorize the staff at Speech World, LLC. to render speech/language/general motor and/or authority treatment for my child.

- We are a training facility and we may have students/interns observing/performing therapy.

RELEASE OF INFORMATION

This authorization, or copy of the same:

- Permits the release to Speech World, LLC. of any medical, educational, or other information necessary for treatment and/or to process claim information for services rendered by Speech World, LLC.
- Permits Speech World, LLC. to disclose any information in connection with the patient's treatment to any physician, therapist, audiologist, educational authority, a government agency (including Medicaid), insurance company and/or other health professionals requesting information either verbally or in writing.
- Permits Speech World, LLC. to share information to designated parties by phone, cell phone, fax and/or e-mail.
- Permits Speech World, LLC. to share information about your child verbally or in written form to:

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REIMBURSEMENT COVERAGE

- The patient herby assigns Speech World, LLC. to request all private medical insurance benefits (both primary and secondary) and any other benefits to which the patient may be entitled, for any therapy services rendered by the Speech World, LLC. staff.
- The patient authorizes and directs Speech World, LLC. to apply and fill all such benefits on behalf of the patient.
- The patient is responsible for obtaining ALL authorization information for therapy services.
- The patient agrees that he/she shall be responsible for ALL charges that are not covered by the insurance provider.

Parent/Guardian Signature Date

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Financial Policy

Please understand that payment for services is part of our relationship. All co-payments and deductible balances are due at the time of service unless previous arrangements have been made with a billing coordinator. We accept check or credit cards. Zelle, Venmo, Cashapp, Apple Pay, Paypal. **Insurance is a contract between you and your insurance company.** We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company, we require that you disclose all insurance information, including primary and secondary insurance, as well as any change of insurance information. **Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. We are not responsible to track number of visits or authorization but will try to keep you informed when an issue arises.** If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including, but not limited to, those charges above the usual and customary allowance.

Parent/Guardian Signature Date

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HIPAA

By signing below, I agree that I have received a copy of Speech World, LLC. HIPAA policy and privacy practices.

Parent/Guardian Signature Date

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Texting

By signing below, I agree that members of Speech World, LLC. can contact client/caregiver via text message regarding scheduling and/or patient progress.

Parent/Guardian Signature Date

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No-Show Policy

By signing below, I agree that I am aware that Speech World, LLC. therapists take great pride in helping your child succeed. Consistent attendance to therapy is required to meet our common communication goals. If your child misses a regularly scheduled appointment with less than 24 hours' notice or you no show to your appointment without rescheduling, you will be responsible for a $20 fee for each missed session. Your child may be dismissed from therapy if you miss more than 10% of scheduled appointments.

Parent/Guardian Signature Date

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