Speech Therapy
Center of Excellence

5516 SOUTH FORT APACHE ROAD, SUITE 130
LAS VEGAS, NEVADA 89148
Tel. (702)641-8255 (TALK) * Fax (702)399-8255 (TALK)
website: speechtherapycenterlv.com
Jil M. Gertz, M.A./CCC-SLP Shelley Paulson, M.S./CCC-SLP
ASHA Certified, Nevada Licensed Speech Language Pathologists

MEDICAL INFORMATION RELEASE FORM

(HIPAA RELEASE FORM)

Name:_____ Date of Birth:_____

RELEASE OF INFORMATION

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Signed:_____Date:_____

Witness:_____Date:_____

Patient name: _____

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ASHA Certified Nevada Licensed Speech Language Pathologists
Shelley Paulson, MS/CCC-SLP
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Speech Therapy Center of Excellence is devoted to the care and treatment of our patients. Our therapists create a unique and specific treatment plan for each of their patients. Preparation time is used to select specific tools and materials for individualized sessions. When a patient does not show for an appointment or give sufficient notice to cancel an appointment, the treatment plan is disrupted and we lose the opportunity to accommodate an alternate patient. Please respect our therapists' time and efforts on your behalf.

NO-SHOW/LATE CANCELLATION CHARGE POLICY

A cancellation is considered late when call is received with less than a 24-hour notice. All no-shows and late cancellations are subject to a charge of $50.00 for the missed appointment. It is further understood that this fee is not a billable charge for insurance purposes and that it is the patient/guarantor's responsibility for payment of the no-show/late cancellation charge.

Charges will be implemented as follows:

- The first no-show/late cancellation charge will be due on or before the next appointment.
- The second no-show/late cancellation charge will be due upon occurrence; patient will be discharged and the referring physician will be notified.

TARDINESS POLICY

If you arrive 10 minutes late for your scheduled appointment your therapist will see you for a shortened session. Should your arrival time be beyond 10 minutes late, you will not be seen. The appointment will be cancelled and rescheduled if possible. Two late arrivals will result in discharge and the referring physician will be notified.

YOUR INSURANCE IS ULTIMATELY YOUR RESPONSIBILITY

Please review the following:

- Double check with your insurance company to determine if **AUTHORIZATION** is required for your visits.
- **Please note authorization is not a guarantee of payment. Benefits are reviewed at the time the claim is submitted.**
- If your visit is denied for **ANY REASON,** you will be billed for the services.
- We are **NOT** responsible for checking your benefits; this is a courtesy and we cannot guarantee any information we receive from the insurance company.

NOTE: ALL PARENTS MUST REMAIN IN THE OFFICE WHILE CHILD IS BEING TREATED.

I have read and understand the above policies:

_____ _____

Signature Date

Speech Therapy Center of Excellence

Patient Registration Form

Referring Physicians Information					
Referred By:			Phone:		
Address:			Fax:		
Patients Information					
Full Legal Name:			SSN:		
Address			City/State/Zip:		
Home Phone	Cell Phone	Male □ Female □	Date of Birth	Age:	Martial Status:
Email Address:		Emergency Contact Person:		Emergency Contact Phone:	
If Patient is a minor fill-out below:					
Mother's Name:			Father's name:		
Mother SSN:	Mother Date of Birth:		Father SSN:	Father Date of Birth:	
Mother's Work Phone:			Father's Work Phone:		
If Married Spouse's Information:					
Spouse's Name:			Spouse's Phone:		
Address (if different):			City/State/Zip:		
Primary Insurance Information					
Company:			Phone:		
Address:			City/State/Zip		
Insured:			Relationship:		
Policy Number:			Group Number:		
Secondary Insurance Information					
Company:			Phone:		
Address:			City/State/Zip		
Insured:			Relationship:		
Policy Number:			Group Number:		

I authorize **Speech Therapy Center of Excellence, Inc.** and/or their billing service to bill my insurance for any/all services rendered on the person listed above. I also allow my insurance to send payments directly to **Speech Therapy Center of Excellence, Inc.** I understand that I am responsible for any co-pays, co-insurance and /or deductibles not covered by my insurance at the time services are rendered Should insurance coverage terminate prior to or during the time the patient is receiving services, the patient will be liable for the entire billed amount of those services. Patient is solely responsible for notifying the office of any insurance changes, additions or deletions. Insurance is billed as a courtesy; the patient is financially responsible for all unpaid balances.

If for any reason a collection agency is required to collect outstanding funds, I understand that I am responsible for collection fees as well.

The information stated above, to the best of my knowledge, is correct and complete:

Signature Print Name Relationship Date