Insurance Intake & Consent Form

Patient Information:

Name (Last, First):_____ Age:_____ DOB:_____ Gender:_____

Mailing Address:_____ Marital Status:_____

Pediatrician/PCP:_____ Phone/Office #:_____

PCP Address:_____ Fax #:_____

Primary Diagnosis:_____ Primary Numeric Diagnosis:_____

Responsible Party:

Name (Last, First):_____ Age:_____ DOB:_____Gender:_____

Address:_____ Marital Status:_____

Relationship to Patient:_____ Home Phone:_____

Cell phone:_____ Email Address:_____

Primary Insurance Policy:

Insurance Company:_____ Phone number:_____

Address:_____

Policy Holder:_____ DOB:_____ Relation to Patient:_____

Policy/Member #:_____ Group #:_____ Employer:_____

Secondary Insurance Policy:

Insurance Company:_____ Phone number:_____

Address:_____

Policy Holder:_____ DOB:_____ Relation to Patient:_____

Policy/Member #:_____ Group #:_____ Employer:_____

Consent and Release

I grant authorization and consent to Speech Innovations of Central Florida, LLC for the evaluation and treatment of the above named patient for any recommendation of speech and language therapy, and certify that no guarantee of assurance has been made as to the results obtained under the care of Speech Innovations of Central Florida, LLC.

Payment Requirements & Financial Responsibility: Speech Innovations of Central Florida, LLC is not an in-network provider with all insurance carriers. We currently accept Medicaid, private pay, and select private insurance plans. If Speech Innovations of Central Florida, LLC is out-of-netowrk with your insurance carrier, you will be provided with a receipt containing the medical diagnosis and treatment codes needed for you to submit for reimbursement. I understand that I am financially responsible for all charges whether or not paid by above insurance. I promise to pay Speech Innovations of Central Florida, LLC all copayments, deductibles, and coinsurance amounts for services rendered to or on behalf of the patient upon receipt of invoice from Speech Innovations of Central Florida, LLC. Invoices for services are sent on the first (1st) of the month for all therapy session charges from the previous month. YOU ARE REQUIRED TO PAY THE INVOICES ON OR BEFORE THE 15TH OF EACH MONTH. Payment is accepted in the form of cash and check only; checks payable to Speech Innovations of Central Florida, LLC. A late payment charge of $35 will be charged for invoices paid after the due date. A $25 service charge will be required for any returned checks. All services will be suspended on any account with a balance greater than $600 until a full payment is made. Please call us promptly if you foresee a payment problem and we will make every attempt to meet your needs. Sliding scale fee rates are available in cases of financial need. Speech Innovations of Central Florida, LLC fee schedule is as follows: Evaluation $150, 1 hour of treatment $90, 45 minutes of treatment $67.50, 30 minutes of treatment $45.

Cancellation/ No-Show Policy: I understand Speech Innovations of Central Florida, LLC will charge me $25 for missed visits and/or cancellations within 24 hours.

By signing below you are agreeing to all terms and conditions of this agreement.

Signature_____ Print Name_____ Date_____

Speech Innovations of Central Florida, LLC
Jane Autenrieth MA, CCC-SLP
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