Client Information Form

Personal Information:

Child's Name: _____
DOB: _____
Parents/Guardians:_____
Address: _____
Cell phone:_____
Email address: _____

I am paying privately for my child's evaluation and/or therapy ____yes ____ no

Insurance Information:

Primary Insurance Company: _____
Type of Insurance Plan (PPO, HMO, etc.): _____
Child's Insurance ID #:_____
Subscriber's Name: _____
Subscriber's DOB: _____

I have called my insurance company to verify my child's speech and (initial) language evaluation and/or therapy benefits Maximum number of visits allowed per calendar year: _____
Copay: _____
Is a referral on file for this visit? _____
Do you have a deductible for speech/language/feeding services? If so, what is your deductible amount?_____

Pediatrician Information:

Child's Pediatrician:_____
Pediatrician's phone number:_____

I certify that the above information is accurate and up-to-date.

Signature of Parent or Guardian: _____ Date: _____

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