Chandler Speech and Language Services, llc
Putting the pieces together

Telephone: 678.288.9770 • Fax: 678.288.9774 • Email: info@chandlerspeech.com

Patient Intake and Financial Form

Patient Name: _____ DOB: _____

Home Address: _____

_____

Home Phone: _____ Cell Phone: _____

E-mail address: _____

Mother's Name: _____ DOB: _____

Father's Name: _____ DOB: _____

Pediatrician/Doctor:

_____

Clinic Name:

_____

Phone: _____ Fax: _____

Child's Diagnosis (if known) and Year:

_____

Reason for Referral:

_____

INSURANCE INFORMATION

Primary Insurance: _____ Phone: _____

Mailing Address for claims:_____-

_____

Subscriber's Name: _____Subscriber's DOB: _____

Policy ID #: _____Group #: _____

Employer/Group Name:_____

Katy Beckitt Waiver: □ Yes □ No

Medicaid: □ Yes □ No □ Peachstate

Medicaid #: _____

My signature indicates that, to the best of my knowledge, all information provided above is accurate and current. I understand if additional service time is requested on my part above what is recommended, I agree to pay the current private pay rate for any additional service time. I understand that if my insurance or Medicaid information changes at any time, it is my responsibility to notify *Chandler Speech and Language Services, LLC* of the noted changes. Failure to do so will result in my responsibility for payment of services if insurance/Medicaid denies services due to lack of authorization and/or verification of benefits.

Signature: _____ Date: _____

_____

Name of Person Completing This Form

_____

Relationship to Patient