Yardley Speech and Language

PATIENT REGISTRATION FORM

Please present your child's insurance card so that a copy can be made.

PATIENT (CHILD) INFORMATION

First Name_____ Middle Name_____ Last Name_____

Date of Birth_____ Pediatrician_____

SSN_____

Street Address:_____

City/Town_____ State_____ Zip_____

-

PARENT / GUARDIAN INFORMATION

First Name_____ Middle Name_____ Last Name_____

Relationship to Child_____

Date of Birth_____

SSN_____

Email Address:_____

Street Address:_____

City/Town_____ State_____ Zip_____

Cell Phone_____

Home Phone_____

EMERGENCY CONTACT (Close Friend or Relative not living with you)

First Name_____ Last Name_____

Relationship to Child_____

Email Address:_____

Street Address:_____

City/Town_____ State_____ Zip_____

Cell Phone_____

Home Phone_____

REGISTRATION FORM (Page 2)

AUTHORIZATION FOR TREATMENT AND FINANCIAL RESPONSIBILITY

I authorize Jennifer Niemeyer, M.S. CCC-SLP to provide treatment and to release medical information to my insurance for services rendered to my minor child (dependent) as may be necessary for payment of Jennifer Niemeyer, M.S. CCC-SLP claims.

I understand that I am financially responsible to Jennifer Niemeyer, M.S. CCC-SLP for all charges. I also understand that payment is due at time of service and that a fee may be charged for any missed appointment not canceled prior to 24 hours before the scheduled session.

_____ _____

DATE PARENT / GUARDIAN NAME (please print)

_____

PARENT / GUARDIAN SIGNATURE

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I authorize the release of medical and/or speech and language information for my minor child necessary for the use of speech/language therapy of the child by Jennifer Niemeyer, M.S. CCC-SLP including test results, treatment, therapy and other medical management for payment, authorizations and Quality reviews.

_____ _____

DATE PARENT / GUARDIAN NAME (please print)

_____

PARENT / GUARDIAN SIGNATURE

CONSENT OF TREATMENT FOR MINOR CHILD

I hereby authorize Jennifer Niemeyer, M.S. CCC-SLP to provide speech/language therapy to my minor child. I further authorize the following adults (over age 18) to act as my agent when presenting my minor child for speech-language therapy, and assign authority to them to allow treatment, including therapy and evaluations.

_____ _____

DATE PARENT / GUARDIAN NAME (please print)

_____

PARENT / GUARDIAN SIGNATURE

_____	_____	_____	_____
PRINTED NAME OF AGENT	RELATIONSHIP	Parent Initials	Date
_____	_____	_____	_____
PRINTED NAME OF AGENT	RELATIONSHIP	Parent Initials	Date

REGISTRATION FORM (Page 3)

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

_____ _____
PATIENT NAME DATE OF BIRTH

_____ _____
DATE PARENT / GUARDIAN NAME (please print)

_____
PARENT / GUARDIAN SIGNATURE

SIGNATURE COULD NOT BE OBTAINED ( )REFUSED ( )

EMPLOYEE / WITNESS DATE _____

IF YOU HAVE DESIGNATED AGENTS AUTHORIZED TO PRESENT YOUR CHILD FOR CARE AND AUTHORIZE TREATMENT, DO YOU GIVE PERMISSION FOR THE SAME AGENT TO RECEIVE MEDICAL INFORMATION? Choose one: YES NO

Parent / guardian initials _____

IF WE ARE TRYING TO CONTACT YOU WITH MEDICAL/SPEECH/LANGUAGE TREATMENT INFORMATION AND REACH VOICEMAIL, DO YOU AUTHORIZE US TO LEAVE A DETAILED MESSAGE ON THAT VOICEMAIL?

HOME NUMBER: YES NO
CELL NUMBER: YES NO
WORK NUMBER: YES NO

IF YOU SELECT “NO” WE WILL ONLY LEAVE A MESSAGE THAT WE CALLED AND YOU WILL NEED TO RETURN OUR CALL.

DO YOU AUTHORIZE USE OF TEXT MESSAGING WITH YOU OR YOUR AGENTS THAT CONTAINS MEDICAL/SPEECH/LANGUAGE TREATMENT INFORMATION?

YES NO

NOTE: We may also disclose PHI to your child’s other health care providers when such PHI is required for them to treat him/her, receive payment for services they render to him/her, or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of health care professionals, or for health care fraud and abuse detection or compliance. We may use your child’s PHI for purposes of calling your home or alternate location and leaving a message or voice mail or in person in reference to any calls pertaining to his/her clinical care, including test results among others, unless or until revoked by you in writing. We may mail to your home or other alternate location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements, unless or until revoked by you in writing.