**Monica LaSalle & Associates, Speech Language Pathology Services.**

**ENROLLMENT FORM**

The patient/guardian shall complete this form and submit it to the center prior to the Patient’s first day of attendance. Information printed on this form shall be kept current.

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| **PATIENT INFORMATION** |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | Name (Last, First, MI) | Home Address (Street, City, State, Zip) | Telephone # | Date of Birth (mm/dd/yyyy) | Date of Evaluation | |
| |  |  | | --- | --- | | Name of Physician | Address (Street, City, State, Zip) | |
| **Name of other specialist involved in Patient’s care** |
| |  |  |  | | --- | --- | --- | | Physician | Specialty | Phone Number | |
| |  |  |  | | --- | --- | --- | |  |  |  | |
| |  |  |  | | --- | --- | --- | |  |  |  | |
| |  |  |  | | --- | --- | --- | |  |  |  | |
| Medical Diagnosis: |
| Medications: |
| Current therapy plan: PT OT ST Counseling Frequency: |
| History of illness: |
| **EMERGENCY CONTACT** |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | Relationship to Patient | Name  Home Address (Street, City, State, Zip) | Telephone # | Cell Phone # | E-mail Address | |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | |  |  |  |  |  | |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | |  |  |  |  |  | |
|  |
| **INSURANCE INFORMATION** |
| |  |  |  |  | | --- | --- | --- | --- | | Primary Insurance Co. | Policy # | ID # | Group # | |
| |  |  |  |  | | --- | --- | --- | --- | | Policy Holder | Policy Holder SSN # | Secondary Insurance | Policy Holder DOB | |
| **CANCELLATION POLICY** |
| |  | | --- | | I understand that Warrior Cognitive and Psychological Services has given me a weekly appointment time which I agree to keep. If I am unable to keep my appointment, I understand that WCPS has a 6-hour cancellation notice policy. If I do not cancel my appointment within 6 hours, I understand that I will be responsible for a $25 cancellation fee payable at my next scheduled appointment. | |
| **AUTHORIZATIONS** |
| * I AUTHORIZE/ DO NOT AUTHORIZE Warrior Cognitive and Psychological Services to discuss my evaluation results with my   ∆ Medical Doctors ∆ other medical professionals ∆ other rehab professionals   * I authorize the release of any medical or other information necessary to process insurance claims. * I authorize payment of my medical benefits to Warrior Cognitive and Psychological Services. * I acknowledge receipt of the practice’s “Notice of Privacy Practices.” * I understand that I am financially responsible for all services performed by the therapists. I am responsible for all services deemed not covered or denied by my insurance company. * Any copayment due at time of visit and not paid at that time is subject to a $5.00 service charge. * Any balance sent for collection will be charged the state’s maximum allowable interest rate. * I understand that Warrior Cognitive and Psychological Services has a 6-hour cancellation notification requirement. I also understand that if I cancel in less than 6 hours of my appointment, I am responsible for a $25 cancellation fee. * I understand that if my Patient misses more than 3 sessions per quarter, that he/she may be discharged from therapy until I/we can commit to another time/day/date in which we can participate in therapy on a more consistent basis. * I understand that failing to disclose all insurance information will result in my being responsible for all unclaimed fees.   **Client’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |