a speech path
Speech, Language
and Communication Therapy

Date: _____/_____/_____

Please print clearly.

Patient Information

Patient's Name: _____ Date of Birth: _____

Patient's Address: _____

Pediatrician: _____ Phone: _____

Parent Information

Mother's Name: _____

Father's Name: _____

Please number in order of preference for contact:

_____ Home Phone: _____

_____ Cell Phone: _____ □ Mother □ Father

_____ Work/Other: _____ □ Mother □ Father

_____ Email Address: _____

Person Responsible for Account

Name: _____

Address: _____

Employer: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Insurance Information

Insurance Provider: _____

Insurance Address and Phone: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

ID #: _____ Group #: _____

Authorization to Communicate Via Email

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires that all health care records and other individually identifiable (personal) health information (PSI) used or disclosed to A Speech Path in any form—electronically, on paper, or orally—be kept confidential.

I understand that A Speech Path's email is not encrypted and cannot be secured from inadvertent disclosure of PSI to third persons once the information is sent via email.

_____ In spite of the risk of inadvertent disclosure of my/my child's PSI, I authorize A Speech Path to send information that may include PSI via email, to any email address provided to A Speech Path.

_____ In spite of the risk of inadvertent disclosure of my/my child's PSI, I authorize A Speech Path to send information that may include PSI via email, to the 3rd parties of Pam Heitman/Derey Edmonds who provide insurance billing services for A Speech Path.

_____ I understand that I am responsible for providing, **in writing**, any request that A Speech Path no longer email information to one or all email addresses provided.

Terms of Agreement

I hereby authorize A Speech Path to:

Initiate an evaluation for the above-named patient and provide speech-language pathology services if deemed appropriate and as agreed upon;

Release patient information as required by appropriate agencies, billing services, and/or insurance companies;

Provide evaluation findings and therapy information to the patient's primary care physician or pediatrician for the purpose of coordinating patient care.

I understand that A Speech Path will bill my insurance as a courtesy to me. I hereby authorize all insurance payments to be paid directly to A Speech Path, Inc. and acknowledge that I am financially responsible for all unpaid balances.

Signature: _____ Date: _____

Parent/Legal Guardian

a speech path
Speech, Language and Communication Therapy

Kate Pilant, M.S., CCC-SLP
1817 Queen Anne Ave. North
Suite 201
Seattle, WA 98109

206•321•1185

Kate@ASpeechPathSeattle.com
www.ASpeechPathSeattle.com