Capstone Speech Therapy
4062 Peachtree Rd NE, Ste 121
Atlanta, GA 30319
Ph: 404-909-5574 Fax: 844-783-6454

Patient Information

Patient's Name: _____ Date of Birth: _____SSN:_____

Address: _____ City:_____ Zip: _____

Home Phone: _____Cell Phone: _____

Primary Care Physician: _____ Physician's Phone: _____

Insurance Information

Health Insurance Carrier: _____ Health Insurance Phone: _____

Member ID: _____ Group ID: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Address (if different): _____ City:_____ Zip: _____

Do you have a Secondary Insurance? _____ Yes _____ No

Secondary Health Insurance Carrier: _____ Health Insurance Phone: _____

Member ID: _____ Group ID: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Address (if different): _____ City:_____ Zip: _____

I request that payment of authorized insurance benefits be made on my behalf to the provider for any medical services provided to me by that organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, my insurance carrier or other medical entity. A copy of this authorization will be sent to my insurance company or other entity if requested. The original will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services received by the provider.

By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

Signature: _____ Relationship to Patient: _____ Date: _____