Pamela Rowe, MA, CCC-SLP, LLC

Pediatric and Adult Speech and Music Therapy
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Adult Patient Information and Authorization

Patient element_1 DOB element_2 Age element_3
Caregiver element_4
Address element_8
Phone element_9 Employment element_10
Insurance element_11 Member ID element_12
Insurance Group# element_13 Insurance Phone Number element_14
Doctor element_15 Phone element_16
Reason for Evaluation element_17

Authorization

I authorize Pamela Rowe, MA, CCC-SLP, LLC to evaluate and provide therapy. I understand that I will be responsible for payment at the time of service. I authorize communication between Pamela Rowe, MA, CCC-SLP, LLC and my insurance company for coordination of payment. I authorize verbal and written communication between Pamela Rowe, MA, CCC-SLP, LLC and my doctor for coordination of care. **CANCELLATIONS MUST BE COMMUNICATED WITH YOUR THERAPIST AT LEAST 24 HOURS IN ADVANCE TO AVOID A CANCELLATION FEE OF $30.**

element_18
Printed Name of Patient

element_19
Patient's Signature

element_20
Date