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Pediatric and Adult Speech-Language Therapy
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Patient Information

Patient_____ DOB_____ Age____

Caregiver_____

Address_____

Phone_____

Employment_____ Phone_____

Insurance_____ Member ID_____

Insurance Phone Number_____

Doctor_____ Phone_____

Reason for Evaluation_____

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.

_____ _____

Printed Name of Patient Patient's Signature

_____

Date