***SUBURBAN PEDIATRIC SPEECH and FEEDING CONSULTING***

Aurora, IL 60504

PATIENT NAME: ______________________________________________
(Last) (First)

BIRTH DATE: _______________________

PH#:_________________________________

ADDRESS: _________________________________________________

ZIP: ___________________________________

RELATIONSHIP TO GUARANTOR: SELF___________ CHILD___________ OTHER_________ __________________________

PRIMARY PHYSICIAN INFORMATION:

NAME: __________________________________________

ADDRESS: ______________________________________________________

PH#:______________________________

REFERED BY/HOW DID YOU HEAR ABOUT US?
________________________________________________________

***GUARANTOR'S INFORMATION***

NAME: _________________________________________

BIRTH DATE: ___________________

SS#___________________

ADDRESS: ____________________________________________________________

PH# ____________________________ EMAIL: ________________________________________

EMPLOYER NAME AND ADDRESS: ______________________________________

PH#: ____________________________

SPOUSE NAME: ___________________________________

BIRTH DATE: ________________________ SS# __________________

EMPLOYER NAME AND ADDRESS: ________________________________________________

PH#: ___________________ EMAIL: _________________________________________

EMERGENCY CONTACT NAME: _________________________________________
(Outside of residing address)

ADDRESS: ______________________________________________________

ZIP: ________________________________________

PH#: __________________________________ EMAIL: _____________________________________

***INSURANCE AND BILLING INFORMATION***

PRIMARY INSURANCE COMPANY: ______________________________________________
INSURED: _____________________________________

ID#___________________ Group#________________ Address: ______________________________

SECONDARY INSURANCE COMPANY: ___________________________________________
INSURED: _____________________________________

ID#___________________ Group#_______________ Address: _______________________________

AUTHORIZATION TO RELEASE INFORMATION:

I HEREBY AUTHORIZE SUBURBAN PEDIATRIC SPEECH AND FEEDING CONSULTING TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO FILE AND/OR PROCESS MEDICAL CLAIMS WITH MY INSURANCE COMPANY(S).

ASSIGNMENT OF BENEFITS:

I HEREBY AUTHORIZE DIRECT PAYMENT OF MEDICAL BENEFITS TO SUBURBAN PEDIATRIC SPEECH AND FEEDING CONSULTING FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO SUBURBAN PEDIATRIC SPEECH AND FEEDING CONSULTING FOR CHARGES NOT COVERED BY THIS ASSIGNMENT. IN SOME CASES, OUR FEE IS NOT COVERED IN FULL BY YOUR INSURANCE COMPANY. THIS

BALANCE DUE INCLUDES PROVISIONS SET BY YOUR INSURANCE COMPANY SUCH AS CO-PAYMENTS, DEDUCTIBLES AND "UNUSUAL AND CUSTOMARY" ALLOWANCE.

GUARANTEE OF PAYMENT:

IN CONSIDERATION OF ALL MEDICAL SERVICES GIVEN BY SUBURBAN PEDIATRIC SPEECH AND FEEDING CONSULTING TO THE PATIENT NAMED ABOVE, I AGREE TO PAY TO SUBURBAN PEDIATRIC SPEECH AND FEEDING CONSULTING ALL FEES AND CHARGES MADE FOR SERVICES, WHICH MAY INCLUDE THE COST OF COLLECTION AND/OR REASONABLE ATTORNEY'S FEES. PAYMENT IS DUE AND PAYABLE WITHIN 30 DAYS OF THE BILLING DATE.

I AGREE TO PAY MY CO-PAYMENT AND DEDUCTIBLE AT THE TIME OF SERVICE VIA CREDIT CARD, CHECK OR CASH. THIS ARRANGEMENT IS PART OF MY CONTRACT WITH MY INSURANCE COMPANY. FAILURE ON THE PART OF SUBURBAN PEDIATIRC SPEECH AND FEEDING CONSULTING TO COLLECT CO-PAYMENTS AND DEDUCTIBLERS FROM PATIENTS CAN BE CONSIDERED FRAUD. PLEASE HELP UPHOLD THE LAW BY PAYING YOUR CO-PAYMENT AT EACH VISIT.

I HEREBY CERTIFY TO YOU THE FOREGOING INFORMATION IS TRUE AND COMPLETE. I HAVE READ AND HEREBY AGREE TO BE BOUND BY THE TERMS OF THESE AGREEMENTS AS SET FORTH. A PHOTOCOPY OF THESE ASSIGNMENTS SHALL BE AS VALID AS THE ORIGINAL.

DATE___________________________________ SIGNATURE________________________________________

PRINT NAME_____________________________