

**PATIENT INFORMATION FORM [PLEASE BE COMPLETE]**

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ DOB: \_\_\_\_\_

CITY: \_\_\_\_\_ NC ZIP: \_\_\_\_\_ EMAIL: \_\_\_\_\_

PARENT / GUARDIAN NAME: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK: \_\_\_\_\_ CELL: \_\_\_\_\_

PEDIATRICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

PED'S PRACTICE NAME: \_\_\_\_\_ FAX #: \_\_\_\_\_

WHO MAY WE THANK FOR THIS REFERRAL? \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_

I.D. # \_\_\_\_\_ GROUP #: \_\_\_\_\_

POLICYHOLDER: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

POLICYHOLDER'S DOB: \_\_\_\_\_

CLAIMS ADDRESS: \_\_\_\_\_

HAS DEDUCTIBLE BEEN MET? YES \_\_\_\_\_ NO \_\_\_\_\_ AUTH REQ'D? \_\_\_\_\_

COPAY AMOUNT \$ \_\_\_\_\_ AND / OR \_\_\_\_\_ %

MEDICAID I.D. # \_\_\_\_\_ EXPIRATION: \_\_\_\_\_

**BY SIGNING BELOW, I AGREE THAT:**

- Payments for all professional services rendered are the responsibility of the patient regardless of insurance coverage. It is our policy for the patient to pay for services unless other arrangements have been made in advance.
- I have been informed of and will adhere to the CANCELLATION POLICY.
- Insurance Authorization: I hereby authorize Carolina Pediatric Dysphagia to furnish information to the insurance carriers concerning my evaluations and therapy and I hereby assign payment to Carolina Pediatric Dysphagia for services rendered to my dependent. I understand that I am responsible for any amount not covered by my insurance.
- **I give my permission to allow CPD to email any pertinent forms pertaining to my child at the above email address listed.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_