DISCOVERING EXPRESSION
SPEECH & LANGUAGE

Patient Intake

Patient Information

Child's First Name:_____ Child's Last Name:_____
Child's Birth Date:_____Pediatrician:_____
Parent/Guardian's Name:_____
Mailing Address:_____ City: _____
Phone:(Home)_____ Cell: _____
Emergency Contact: _____ Phone:_____
Email Address: _____

Clinical Information

Please state briefly your area's of concern for your child

_____
_____
_____
_____

Insurance Information

Primary Insurance Company :_____
Name of Policy Holder :_____
Policy ID #: _____ Group #:_____
Secondary Insurance Company:_____
Policy #: _____ Group #: _____

Assignment & Release

I, the undersigned certify that my child has insurance coverage with the insurance company listed above, and assign directly to Discovering Expression Speech and Language Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I nearby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature for all insurance submissions.

_____ _____
Parent/ Guardian Signature Date

3231 Willamette Dr. NE suite C Lacey Wa. 98516