UNIVERSITY OF SOUTH ALABAMA
DEPARTMENT OF SPEECH PATHOLOGY
AND AUDIOLOGY

_____
Account Number

_____
Physician/Therapist

_____
Referring Physician

SECTION A: PATIENT INFORMATION

NAME _____ BIRTHDAY _____
ADDRESS _____
STREET CITY STATE ZIP
SOCIAL SECURITY NUMBER _____ SEX _____ MARITAL STATUS _____
EMPLOYER _____ OCCUPATION _____
WORK PHONE _____ HOME PHONE _____ CELL _____
E-MAIL ADDRESS _____ Can we use this e-mail address to communicate with you regarding health information? _____

SECTION B: SPOUSE I RESPONSIBLE PARTY

NAME _____ BIRTHDAY _____
ADDRESS _____
STREET CITY STATE ZIP
SOCIAL SECURITY NUMBER _____
RELATIONSHIP TO PATIENT_____ HOME PHONE_____ CELL _____
EMPLOYER _____ OCCUPATION _____ WORK PHONE _____

SECTION C: EMERGENCIES

NEAREST FRIEND OR RELATIVE NOT RESIDING WITH YOU _____
ADDRESS _____
TELEPHONE _____ RELATIONSHIP_____

SECTION D: INSURANCE INFOMRATION

Primary:
INSURANCE CO. _____
ADDRESS _____
SUBSCRIBER'S NAME _____
CONTRACT # _____
GROUP # _____
MEDICAID # _____
MEDICARE # _____ STATE OF: _____

Secondary:
INSURANCE CO. _____
ADDRESS _____
SUBSCRIBER'S NAME _____
CONTRACT # _____
GROUP # _____
MEDICAID # _____
MEDICARE # _____STATE OF: _____

FINANCIAL RESPONSIBILITY
The undersigned, in consideration of medical services to be rendered by the Department of Speech Pathology and Audiology to the below name patient, does hereto agree to pay the Department of Speech Pathology and Audiology on demand for said services and incidentals incurred on behalf of such patient.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
The clinic and physician/therapist are authorized to release any medical information required in the processing of applications for financial coverage for all services rendered to the patient.

ASSIGNMENT OF INSUREANCE BENEFITS
I hereby authorize direct payment of medical benefits to the physician/therapist or to whomever he/she designates. I understand that I am personally responsible to the physician/therapist for all charges for service.

Signature: _____ Date: _____

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS/THERAPISTS AND PATIENT
Payment for services rendered is to be made as follows:
"I request that payment of authorized Medicare benefits be made either to me or on my behalf to the Health services Foundation Department of Speech Pathology and Audiology for any services or items furnished me by that physician/therapist or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

Signature: _____ Date: _____