Insurance Intake Form

Patient Name: ____ Date of Birth: __________________________

Gender: ☐M ☐F

Address: ____

City, State, Zip: ____

Home Phone: _______________________________________ Alternate Phone: _______________________________

Marital Status: ☐Single ☐Married ☐Other: __________________________________

Work Status: ☐Employed ☐Full-Time Student ☐Part-Time Student ☐Retired

Insurance Company: ____

Relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other

(If different from above)

Subscriber's Name: ____ DOB: ______________________

Subscriber's Address: ____

City, State, Zip:____ Phone: ___________________________

Subscriber's ID # (please include prefix if applicable) : ____

Group#:____

Employer's Name:_____________________________________ Plan Name:__________________________________

If you were referred by a healthcare provider, please give the referring provider's name, clinic name,

and phone number: ____

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I understand, as the patient and/or above mentioned responsibility party, that I am fully responsible for payment of all charges incurred. I authorize my insurance benefits to be paid directly to Angie Brown M.S.CCC-SLP for services rendered. I understand I am financially responsible for any deductibles, non-covered services or non-authorized services. I authorize Angie Brown M.S. CCC-SLP to release any information requested by my insurance company with regards to payment of benefits.

Signature: ____ Date: ______________________