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_____ Preferred Name: _____

'DWH RI %LUWK _____ 6RFLDO _____

%LRORJLFDO 6H[_____ Gender Identity: _____ Preferred Pronouns: _____

3KRQH (K) _____ (B) _____ (w): _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred method of communication: ☐ Email ☐ Cell phone/ Text ☐ Home Phone

Client primary language? _____ Race: _____

Is there a medical diagnosis that caused the problem? ☐ Yes ☐ No

Describe: _____

Please describe the difficulty that the client is having: _____

Please indicate Whe speech services the client wishes to receive: _____

If client is unable to fill out the form, please fill out the following information:

Person completing this form: _____ Relationship to client: _____ Date: _____

3HUPDQHQW &RQWDFW

Primary Care Physician: _____ Phone: _____

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1DPH _____ 5HODWLRQV

KLS WR WKH FOLHQW _____

+RPH SKRQH _____ &HOO SKRQH _____

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UHPLQGHUV , XQGHUVWDQG WKDW PHVVDJH DQG GDWD UDWHV PD\ DSSO\ DQG WKI

3DWLHQW 1DPH _____

&HOO SKRQH QXPEHU _____ 0RELOH SKRQH FDUULH

6LJQDWXUH _____

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'D\V DQG WLPHV PREFERRED &KHFN DW OHDVW WZR

Day:	Morning:	Afternoon:
Monday	8:00-12:00	1:00-5:00
Tuesday	8:00-12:00	1:00-5:00
Wednesday	8:00-12:00	1:00-5:00
Thursday	8:00-12:00	1:00-5:00
Friday	8:00-12:00	1:00-5:00

,I QRQH RI WKH DERYH WLPHV ZRUN SOHDVH VSHFLI\ DYDLODEOH WLPHV EHORZ

'R \RX KDYH D FDVH PDQDJHU" <HV 1R

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'RHV WKH FOLHQW KDYH D 3RZHU RI $WWRUQH\"

,I \HV SOHDVH SURYLGH D FRS\ RI 3RZHU RI $WWRUQH\

,I \HV QDPH RI 3RZHU RI $WWRUQH\ BBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBB

WSU SPEECH LANGUAGE HEARING CLINIC FINANCIAL POLICY

PART 1: PATIENT INFORMATION

Fill out this form completely. Please print legibly.

Last Name:	First Name:	Middle Initial:

PART 2: WSU SPEECH LANGUAGE HEARING CLINIC FINANCIAL POLICIES

1. The cost of services provided by WSU Speech Language Hearing Clinic is your responsibility, whether you are covered by health insurance or not. Payment is expected at the time of service unless arrangements have been made prior to treatment. WSU Speech Language Hearing Clinic accepts cash, checks and credit cards. Please note: checks must be imprinted with the bank name and the account holder's name.

2. WSU Speech Language Hearing Clinic will process claims for any In Network Private Health Insurance Plans.

3. By giving WSU Speech Language Hearing Clinic your insurance information, you are authorizing WSU Speech Language Hearing Clinic to file a claim with (send a bill to) your insurance company for services rendered.

4. If you do not want WSU Speech Language Hearing Clinic to file a 4.6 d.1 yn5 (l)5.1 (e)9 (a4 (o2 (i)-t)2.3 366.488m d.1 5 (l)-6 (gu.1

By signing below, I am agreeing that I:

1. Have read any understand the SHS Financial Policies as set forth above, and which may be amended from time to time;
2. Am financially responsible to pay for all services that I receive, whether covered by insurance or not;
3. Authorize WSU Speech Language Hearing Clinic to submit a cla2 Tw5.927 -1.LBody <(a)-4 (ge)3 (H)-4.5 (e5w(5 811.7 0C>5

PATIENT PHOTO/VIDEO/AUDIO AUTHORIZATION AND RELEASE FORM

NOTE:

SECTION A. INDIVIDUAL INFORMATION		

SECTION B. PHOTOGRAPHY/VIDEOGRAPHY/AUDIOGRAPHY RELEASE	

For Educational or Training Purposes Within WSU	
☐	☐
For Public Relations Purposes Outside of WSU	