Santa Rosa Speech & Language Services
Jennifer Alwood M.S. CCC-SLP
800 College Ave., Santa Rosa, CA 95404

Patient Information

Last Name:_____ First Name:_____

Address_____ City:_____ Zip Code:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Date of Birth:_____ Age:_____ Occupation:_____

Person Responsible for Payment:_____

Relationship to Patient:_____

Who referred you to this office?:_____

Who is your primary care doctor?:_____

Insurance Information

Primary Insurance:_____
(Please provide your card for copying)

Secondary Insurnace:_____
(Please provide your card for copying)

Authorization to Release Information
I hereby authorize Jennifer Alwood, M.S. CCC-SLP, to: (1) release any information necessary to insurance carriers regarding my treatment; (2) process insurance claims generated in the course of treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Jennifer Alwood, M.S. CCC-SLP on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately unless previous arrangements have been made. A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature
_____ Date _____

Witness
_____ Date_____