

**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 INFORMATION**

<b>Primary:</b>	<b>Secondary:</b>
INSURANCE CO. _____	INSURANCE CO. _____
ADDRESS _____	ADDRESS _____
SUBSCRIBER'S NAME _____	SUBSCRIBER'S NAME _____
CONTRACT # _____	CONTRACT # _____
GROUP # _____	GROUP # _____
MEDICAID # _____	MEDICAID # _____
MEDICARE # _____ STATE OF: _____	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: \_\_\_\_\_