|  The Pauline K. Winkler Speech-Language-Hearing CenterThe College of Saint Rose432 Western AvenueAlbany, NY 12203(518) 454-5263(518) 337-2313INSURANCE REGISTRATION FORM |
| --- |
| PATIENT Information |
| Name: |
|  (Last Name) (First Name) (Middle Initial)  |
| SS/HIC/Patient ID# | DOB:  | Age: | Sex: M or F (Please Circle) |
| Married | Separated | Widowed | Divorced | Single | Partnered | Minor |
| Current address: |
| City: | State: | ZIP Code: |
| Home Phone: ( )  | Cell Phone: ( ) | Work Phone: ( ) |
| Current Address:  |
| City: | State: | ZIP Code: |
| E-mail:  | Whom may we thank for referring you: |
| Patient Employer/School:  | Occupation: |
| Employer/School Address: |
| Employer/School Phone: ( )  |
| In case of emergency who should be notified: Phone: ( )  |
| PRIMARY INSURANCE |
| Person Responsible for Bill:  |
|  (Last Name) (First Name) (Middle Initial) |
| Relation to Patient:  | Birthdate:  |
| Current Address (if different from patient’s):  |
| City:  | State: | ZIP Code: |
| Person Responsible Employed By: | Occupation:  |
| Business Address:  | Business Phone: ( ) |
| City: | State: | ZIP Code: |
| Insurance Company: |
| Subscriber ID # | Group # | Contract # |
| Names of other dependents covered under this plan:  |
| ADDITIONAL INSURANCE |
| Is patient covered by additional insurance? (Please Circle ) |  YES OR NO  |
| Subscriber Name:  | Birthdate: | Relation to Patient: |
| Address (if different from patient’s):  | Phone Number: ( ) |
| City: | State: | ZIP Code: |
| Subscriber Employed by:  | Business Phone: ( ) |
| Insurance Company:  |
| Subscriber ID # | Group # | Contract # |
| Names of other dependents covered under this plan:  |
| ASSIGNMENT AND RELEASE |
| I certify that I, and/or my dependent(s), have insurance coverage with (Names of Insurance Company(ies):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and assign directly to THE PAULINE K. WINKLER SPEECH-LANGUAGE-HEARING CENTER all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.  |
| Signature of Patient, Parent, Guardian or Personal Representative: Date: |
| Please print name of Patient, Parent, Guardian or Personal Representative: Relationship: |