PATIENT REGISTRATION PLEASE PRINT LEGIBLY First Name: Last Name: **RESPONSIBLE PARTY IF PATIENT IS UNDER 18:** First Name: Last Name:	**Patient's Sex :** Male ☐ Female ☐	**Patient's Birth Date** : / / **Responsible Party's Birth Date:** / /	**Patient's Marital Status**: Single ☐ Married ☐ Widowed ☐ Divorced ☐

E-Mail Address	Home Phone:	Patient's Social Security#:
Street Address:	City / State:	Zip Code:
Name of Employer Address:	Business Phone:	Cell Phone:
Person to contact in case of emergency:	Relationship to patient:	Phone:

PRIMARY INSURANCE INFORMATION

Subscriber's name: **Relationship to patient:**		Insurance Company Name / Address:	
Subscriber Social Security#:	Subscriber birth date: / /	Policy #	Group #

SECONDARY INSURANCE INFORMATION

Subscriber's name: **Relationship to patient:**		Insurance Company Name / Address:	
Subscriber Social Security#:	Subscriber birth date: / /	Policy #	Group #

Authorization for Assignment of Benefits/Information Release:

I, (patient/guardian) , herby authorize Hudson Valley Speech &

Swallowing Therapy PLLC, to apply for benefits on my behalf for the services I have received, from my Insurance Carrier listed above. I authorize payment of medical benefits to be made directly to Hudson Valley Speech & Swallowing therapy PLLC for any services furnished to me by the practitioner. I understand that I must select Hudson Valley Speech & Swallowing Therapy PLLC and if I have not done so I will be responsible for all services provided. I also understand that my Insurance Carrier may not cover all services provided and I may be responsible for any services that are non-covered. I certify that the Insurance information that I have provided is accurate and understand that if it is not accurate I will be financially be responsible for the services provided. I understand that I will be responsible for any fees relating to my account being sent to an outside collection agency, attorney, in addition to any court costs in an attempt to collect for the services provided. I understand that I am responsible for all administration fees assessed on my account, i.e. co-pay not paid fee, returned check fees, no-show and late cancellation fees, etc. I authorize you to release to my insurance company or their agent information concerning health care, advice, medical records, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits. I permit a copy of this authorization to be used in place of an original.

Signature ____ **Date** / /