Date of Intake : _____

Speech Pathology Solutions, LLC

Intake Form

Name: _____ D.O.B. : _____

Parent Name:_____Phone Number:_____

What type of service? ST PT OT

Diagnosis: _____

Insurance: _____

Group #:_____ ID #_____

Phone # on Ins Card: _____

E-Mail Address: _____

Day/Time Preference: _____

Doctor Name: _____

Doctor Phone Number: _____

How did you hear about us? _____

Insurance Verification Questions/ Office Use:

Diagnosis codes _____ Billing Codes _____

Eligible: yes/no Referral: yes/no Pre-Authorization: yes/no

What we need for authorization: _____

_____

Visits Per Year: _____ Co-Pay: _____ Deductible: _____

Is Evaluation Covered? YES NO

Reference #: _____