Articulate Speech and Language Therapy, LLC
4325 Laurel Street, Suite 100
Phone: 907-569-5665 Fax: 866-839-0425

Patient Intake Form

Patient Name: ____

Patient's DOB:________________________Patient's Gender: M F

Patient's Address:____

City: ____________________State: ______________Zip Code:__________Home

Telephone Number:____

Parent/Guardian Printed Name:________________________Date:__________

Cell Phone Number:____

Email Address:____

Parent/Guardian Printed Name:________________________Date:__________

Cell Phone Number:____

Email Address:____

Referring Physician:

Name:____

Address:____

City: ____________________State: ______________ Zip Code:__________

Physician Phone Number:______________Fax:____________________

Primary Insurance Information:

Primary Insurance Name:____

Address:____

City: ____________________State: ______________ Zip Code:__________

Primary Insurance Telephone Number:______________Fax:______________

Subscriber's Name:__________________________Subscriber's DOB:__________

Subscriber's Policy Number:______________Group Number:______________

Subscriber's Address (if different from patient):______________________

City: ____________________State: ______________ Zip Code:__________

Telephone Number:____

Email address: ____________________Relationship to Patient: __________

Subscriber's Employer:____

Secondary Insurance Information (If Medicaid, Attach Sticker):

Secondary Insurance Name:____

Address:____

City: ____________________State: ________________ Zip Code:__________

Secondary Insurance Telephone Number:________________Fax:________________

Subscriber's Name:______________________Subscriber's DOB:______________

Subscriber's Policy Number:________________Group Number:______________

Subscriber's Address (if different from patient):______________________________

City: ____________________State: ________________ Zip Code:__________

Telephone Number:____

Email address: ____________________Relationship to Patient: __________

Subscriber's Employer:____

Tertiary Insurance Information (If Medicaid, Attach Sticker):

Tertiary Insurance Name:____

Address:____

City: ____________________State: ________________ Zip Code:__________

Tertiary Insurance Telephone Number:________________Fax:________________

Subscriber's Name:______________________Subscriber's DOB:______________

Subscriber's Policy Number:________________Group Number:______________

Subscriber's Address (if different from patient):______________________________

City: ____________________State: ________________ Zip Code:__________

Telephone Number:____

Email address: ____________________Relationship to Patient: __________

Subscriber's Employer:____

I authorize speech therapy services to be performed for ____________________(patient) and agree to assign benefits for speech therapy services to Articulate Speech and Language Therapy, LLC/ Anna Spilker. Services may be delivered via a secure telehealth platform as necessary due to health or travel restrictions.

I have been provided a copy of Articulate Speech and Language Therapy, LLC Notice of Privacy Practices. I understand that *on occasion* there may be an observer present in the clinic. I also understand that no personal information will be given out about my child, except that the observer may hear my child's first name during a treatment session.

Parent/Guardian Signature:________________________Date:________________

Parent/Guardian Printed Name:______________________Date:____________