JENNIFER ANN SPEECH THERAPY

www.jenniferannspeechtherapy.com

Phone: 312-420-1901 Email: jenniferschoonoverslp@gmail.com

PATIENT INTAKE FORM

Child's Name	
DOB	
Age	
Address	
Phone Number	
Current School	

MEDICAL HISTORY

History of Speech Disorder	
Current Health	
Pediatrician	
Allergies	
Current Medications	
Last Hearing Test	
History of Ear Infections	
Birth History	
Developmental Milestone History	

ADDITIONAL INFORMATION

Current Concerns	
Age of First Word	
Primary Language	
Referral Source	
Child's Interests	
Preferred Therapy Days/Times	

CREDIT CARD INFORMATION

Name on Credit Card	
Credit Card Number	
Expiration Date	
CVC (3 digit code)	

FINANCIAL POLICY

Jennifer Ann Speech Therapy is committed to helping your child improve on his/her Speech & Language development. The following is a statement of our policy. We do require you to read and sign prior to treatment. A credit card on file is required as a guarantee of payment for any patient responsibilities including out of pocket payment and insurance deductibles. Your credit card will be charged at the end of each month for services rendered for that month.

I hereby authorize Jennifer Ann Speech Therapy to bill the credit card that I have provided above. If for some reason the credit card payment can not be processed I will provide an alternative form of payment. I have read, understand and agree to this policy.

Print Name: _____
Signature:_____

CANCELLATION POLICY

Please cancel within 12 hours of your scheduled therapy session. You will have one excused absence after that your credit card will be billed a $25 dollar cancellation fee.