**Patient Registration Form**

Prior to services being scheduled, your insurance needs to be verified. If necessary, an authorization obtained.  It is suggested that you call the Member Service department at your insurance company and verify what your responsibilities may be regarding copays, deductibles, referrals, etc.  Please remember that benefits quoted are not guarantee of payment per your insurance.

Please complete the registration information to begin the referral process. Email completed information to Jennifer Martinous at [jenm@techaccess-ri.org](mailto:jenm@techaccess-ri.org) or fax to 401.463.3433.

*Accurate and detailed completion of the registration form will help when receiving authorization from insurance companies.*

**Today’s Date:** **Evaluation needed: (please check one)**

**SLP: Communication (AAC)**

**OT: Access (AT)**

|  |  |
| --- | --- |
| **PATIENT INFORMATION** | |
| **Patient’s Name:**  **Street Address:** | **Date of Birth:**  **Phone Number:**  **Email Address:** |
| **Contact Person:** | **Phone Number:**  **Email Address:** |

|  |  |
| --- | --- |
| **INSURANCE INFORMATION** | |
| **Name of Primary Insurance:**  **Patient’s relationship to subscriber:** | **Subscriber’s Name:**  **Date of Birth:** |
| **Name of Secondary Insurance:**  **Patient’s relationship to subscriber:** | **Subscriber’s Name:**  **Date of Birth:** |

* **I understand and agree that I am financially responsible for all co-pays, coinsurance and amounts not covered by my healthcare provider.**
* **I understand that I am obligated to provide ALL insurance information and must notify TechACCESS immediately should this information change. I understand that failure to comply with this policy will result in patient responsibility for any unpaid balances.**

|  |  |
| --- | --- |
| **Parent/Guardian Signature:** | **Date:** |

I have included a copy of the front and back of ALL insurance cards.

I have included a copy of a letter from physician stating relevant diagnosis.