UNIVERSITY OF SOUTH ALABAMA
DEPARTMENT OF SPEECH PATHOLOGY
AND AUDIOLOGY

________________________ Account Number

__________________________ Physician/Therapist

__________________________ Referring Physician

SECTION A: PATIENT INFORMATION

NAME ____ BIRTHDAY ______________________________

ADDRESS ____

STREET CITY STATE ZIP

SOCIAL SECURITY NUMBER ______________________________ SEX

SECTION B: SPOUSE

NAME ____

ADDRESS ____

STREET CITY STATE ZIP

SOCIAL SECURITY NUMBER ___________________________________

RELATIONSHIP TO PATIENT ________________________ HOME PHONE _______________ CELL ________________________

EMPLOYER ___________________________ OCCUPATION ____________________ WORK PHONE __________________

SECTION C: EMERGENCIES

NEAREST FRIEND OR RELATIVE NOT RESIDING WITH YOU ____

ADDRESS ____

TELEPHONE _______________________________ RELATIONSHIP ____

SECTION D: INSURANCE INFOMRATION

Primary: Secondary:

INSURANCE CO ________________________________ INSURANCE CO. ____

ADDRESS ________________________________ MEDICARE # STATE OF: __________ STATE OF: __________

of aplications for financial coverage for all services

I hereby authorize direct payment of medical benefits to the physician/therapist or to whomever he/she designates. I understand that I am personally responsible to the physician/therapist for all charges for service.

Signature: ____ Date: ___________________________

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS/THERAPISTS AND PATIENT

Payment for services rendered is to be made as follows:

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to the Health services Foundation Department of Speech Pathology and Audiology for any services or items furnished me by that physician/therapist or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

Signature: ____ Date: ____________________________________