# CLIENT REGISTRATION FORM

The following information is confidential and will be used for our records only.

Client's Name:______________________________________________
(*Last*) (*First*) (*Middle Initial*)

Home Address:______________________________________________
(*Street*) (*City*) (*State*) (*Zip*)

Home Phone: ( )____________________ Work Phone: ( )____________________

Cell Phone: ( ) ____________________ Email: ____________________

Employer's Name:______________________________________________

Employer's Address:______________________________________________

Client's Date Of Birth:__________ Age:__________ Sex:________

If A Minor, Parents - Social Security Number:____________________

If A Minor - Parent(S) Name:______________________________________________
(*Last*) (*First*) (*Middle Initial*)

Emergency Contact Name:____________________ Phone:____________________

Client's Physician:____________________ Phone:____________________

Address:______________________________________________
(*Street*) (*City*) (*State*) (*Zip*)

How Were You Referred:______________________________________________

I, the undersigned, do hereby agree and obligate myself to pay the balance due in consideration for the services rendered by Speech Plus. I understand that all fees are to be paid at the time service is rendered. Filing a claim with a third party reimbursement source shall not relieve me of my obligation to pay for all services rendered. I hereby agree to pay all expenses of collecting unpaid statements, including all attorney's fees and court costs. I further understand that there is a $25.00 service charge on all returned checks.

____________________ Responsible Party ____________________ Relationship to Client

____________________ Date ____________________ Witness