PEDIATRIC SPEECH-LANGUAGE SERVICES
MOLLY THOMPSON, M.S.,CCC-SLP
4325 LAUREL STREET SUITE 100
ANCHORAGE, AK. 99508
PHONE: (907) 562-3994 FAX: 866.861.8204
www.polarspeech.com

The information requested in this form will be kept confidential.
Today's Date _____

GENERAL INFORMATION - ***Please print*** Name of child:
Last_____ First _____ MI _____
Mailing address_____ City_____ State_____ Zip_____
Birth date ____ /____ /____ Age_____ ❑ Male ❑ Female

Responsible Party Name: Last_____ First_____
MI _____ Mailing Address (if different than above) _____
City_____ State_____ Zip_____
Birth date ____ /____ /____ Age_____ ❑ Male ❑ Female
Place of employment_____
Employer: _____

Phone (circle preferred number) Email Address _____ Home_____
Work_____ Cell _____
EMERGENCY CONTACT Name _____Relationship _____Phone _____

Are you using insurance benefits? ❑Y or ❑N Are you: ❑ Primary Policyholder or ❑ Dependent Insurance
Insurance Name: _____ Insurance Company Phone #:_____
Insurance ID #_____ Group #_____ Policyholder's SSN:_____
Policyholder's Name:_____ Policyholder's Birthday:_____
Relationship to Policyholder:_____ Policyholder's Employer_____

Secondary Insurance:
Insurance Name: _____ Insurance Company Phone #:_____
Insurance ID #_____ Group #_____ Policyholder's SSN:_____
Policyholder's Name:_____ Policyholder's Birthday:_____
Relationship to Policyholder:_____ Policyholder's Employer_____

Client's Authorization for Insurance Use
I authorize the release of health care information necessary to process claims generated by Molly Thompson (dba Pediatric Speech-Language Svs).

_____
Parent/Guardian Signature Date

Client's Payment Agreement
I hereby authorize payment directly to Molly Thompson (dba Pediatric Speech-Language Svs) of any benefits due from speech-language eval/therapy. I understand that I am responsible for any amount not covered by insurance.

_____ _____
Parent/Guardian Signature Date