

University of Nebraska Speech-Language And Hearing Clinic
253 Barkley Memorial Center
Lincoln, NE 68583-0731

Patient Registration

Date _____

Name _____ Birth Date _____ Age _____ Sex _____

Address _____ Home Phone _____

City _____ State _____ Zip Code _____

Marital Status: Unmarried Married Widowed

Patient Employer _____ Work Phone _____

Employer Address _____

City _____ State _____ Zip Code _____

Contact Person (not living with you) _____ Phone # _____

Notice to Medicaid/Medicare recipients: ALL Medicaid/Medicare claims require a physician's order prior to service for approval of payment.

Primary Insurance Co. _____ Policy # _____

Insurance Co. Address _____ City, State _____ Zip Code _____

Policy Holder's Name _____ Birth Date _____

Secondary Insurance Co. _____ Policy # _____

Insurance Co. Address _____ City, State _____ Zip Code _____

Policy Holder's Name _____ Birth Date _____

Other Insurance Co. _____ Policy # _____

Insurance Co. Address _____ City, State _____ Zip Code _____

Policy Holder's Name _____ Birth Date _____

Guarantor Information (complete only if person responsible for bill is not patient or parent)

Guarantor Name _____ Home Phone _____

Address _____ City, State _____ Zip Code _____

Employer _____ Work Phone _____

Address _____ City, State _____ Zip Code _____

Referring Information

Primary Care Physician's Name _____

Address _____ City, State _____ Zip Code _____

Do you have a written physician's referral? Yes No

Is your condition due to an accident of any kind? Yes No

Person who referred you to this clinic? (if different from above) _____

Address _____ City, State _____ Zip Code _____

Authorization for Payment and Assignment of Release:

I request that payment of authorized Health Insurance, Medicare and/or Medicaid benefits be made on my behalf to *UNL Barkley Speech-Language and Hearing Clinic* for any services furnished to me by that Clinic.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, or other health insurance agency, any information needed to determine these benefits or the benefits payable for related services.

I understand and agree that I am responsible for all charges or any charge not paid by my insurance company.

Signature of Person Completing Form

Date

Position or Relationship to Client