

PEDIATRIC

Louise Levy, M.S. CCC-A
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Registration Form (Please Print)

Today's Date ____/____/____

Patient Information

Name _____
Last First Middle
Street Address _____ Apt # _____
City _____ State _____ Zip _____ Sex M / F
DOB ____/____/____ Age ____ SS ____-____-____

**New Government regulations require medical offices to ask the following -*

Preferred Language _____ Race _____ Ethnicity _____

Parent / Guardian Information

Name _____ Email _____
Last First Middle
Street Address _____ Apt # _____
Home Phone ____-____-____ Work Phone ____-____-____ Marital Status _____
Referred By _____
Occupation _____
Employer Name _____ Phone _____
Employer Address _____

Send Report To:

Doctor: _____ Phone: _____
Address: _____
Therapist: _____ Phone: _____
Address: _____

All medical records at the medical office of Louise Levy, M.S. CCC-A are strictly confidential and comply with all of the laws set forth in compliance with HIPAA.

I, the undersigned, authorize the release of medical information to any and all parties as determined by practitioner if needed, and as necessary to process insurance claims and, where applicable, comply with federal, state and local requirements. I also authorize payment of benefits to Louise Levy, M.S., CCC-A

I understand and agree that I am responsible for the balance of my account for any professional services rendered, including any unmet deductibles, co-payments and non-covered services, and I authorize ALL insurance payments to Louise Levy, M.S. CCC-A for services rendered.

Parent or Legal Guardian Signature _____

Name of Signer _____ Relation to Patient _____ Date ____/____/____