UNC GREENSBORO
Speech *and* Hearing Center

CLIENT INFORMATION

Today's Date _____ Check one: New Client☐ Returning Client☐

Client's Name (First/Middle/Last):_____

Date of Birth (mm/dd/yyyy): _____Gender: Male☐ Female☐ Other☐

Address: _____City: _____

State: _____Zip:_____ Email: _____

Preferred telephone: (_____)_____ (for messages) Cellphone: (_____)_____ (if different) Cellphone Carrier:_____ (for text messages)

Are you a US Citizen? Yes☐No☐ Are you currently a student or employee at UNCG? Yes☐No☐

Are you currently a student or employee at an area college?Yes☐No☐ If so, where?_____

Are you currently receiving speech/language services elsewhere?Yes☐No☐If so, where? _____

Are you currently living in a skilled nursing facility? Yes☐No☐ If so, where? _____

Emergency Contact Person (First/Last):_____

Relationship to Client: _____ Phone: (_____)_____

Complete this section if the client is under age 18 years or is 18 years and over with a legal guardian.

Legal Guardian (First/Last): _____ Relationship to Client:_____

Address: [same as above] _____City: _____

State: _____Zip: _____ Preferred telephone (for messages): (_____)_____

Complete this section if you have Medicare Part B or PPO (HMO and Medicaid plans are excluded):
Medicare requires a doctor's referral for medically necessary services except when provided by an audiologist once every 12 months. Not all services are covered by insurance and payment by your insurance is not guaranteed. ***Check with your insurance company prior to your appointment if you have questions about coverage of services.***

Primary Insurance: _____Policy or ID #: _____ Group #_____

Other Insurance: _____ Policy or ID #: _____ Group #_____
(Secondary/Supplementary)

Copies or picture of the front and back of your valid Medicare and/or other insurance cards are needed to bill your insurance. Submit prior to your appointment by emailing securely to: billing@csdshc.uncg.edu.

I understand that payment in full is required on the day of service except for services covered by Medicare Part B. I authorize payment of medical benefits to the UNCG Speech & Hearing Center for services rendered.

Signature: _____Date: _____
[Client or Legal Guardian]