Auditory-Verbal Center
2018 Client Registration

FORM MUST BE FILLED OUT COMPLETELY IN PRINT.

OFFICE USE ONLY

Initial Upon Completion: _____

STATUS: ☐ New ☐ Existing

PROGRAM: ☐ AVT - ATL ☐ AUDIO ☐ AVT - MAC ☐ TELE

CLIENT BACKGROUND

Title: _____ Name: _____ _____ _____
First Name *M.I.* *Last Name*

Preferred Name: _____ Gender: ☐ Male ☐ Female Date of Birth: _____ / _____ / _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Primary Email: _____

Home: (_____) _____ - _____ Work: (_____) _____ - _____ Cell: (_____) _____ - _____

Marital Status: ☐ Single ☐ Married ☐ Other County: _____

Employment Status: ☐ Employed ☐ Full Time Student ☐ Part Time Student ☐ Other

Employer: _____ Title: _____

Total Combined Family Income: ☐ Less than $20,000 ☐ $20,001 - $30,000 ☐ $30,001 - $40,000 ☐ $40,001 - $50,000 ☐ $50,001 - $60,000 ☐ $60,001 - $70,000 ☐ $70,001 - $80,000 ☐ More than $80,001

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____ Do You Need An Interpreter? ☐ Yes ☐ No

Race: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Unknown ☐ Other ☐ Decline

PARENT/GUARDIAN CONTACT INFORMATION

PARENT/GUARDIAN 1:

Relationship to client: ☐ None ☐ Parent ☐ Guardian ☐ Caregiver ☐ Grandparent ☐ Child ☐ Spouse ☐ Relative ☐ Friend ☐ Partner

Title: _____ Name: _____ _____ _____
First Name *M.I.* *Last Name*

Race: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Unknown ☐ Other ☐ Decline

Home: (_____) _____ - _____ Work: (_____) _____ - _____ Cell: (_____) _____ - _____

Primary Email: _____

PARENT/GUARDIAN 2:

Relationship to client: ☐ None ☐ Parent ☐ Guardian ☐ Caregiver ☐ Grandparent ☐ Child ☐ Spouse ☐ Relative ☐ Friend ☐ Partner

Title: _____ Name: _____ _____ _____
First Name *M.I.* *Last Name*

Race: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Unknown ☐ Other ☐ Decline

Home: (_____) _____ - _____ Work: (_____) _____ - _____ Cell: (_____) _____ - _____

Primary Email: _____

EMERGENCY CONTACT INFORMATION

Relationship to client: ☐ None ☐ Parent ☐ Guardian ☐ Caregiver ☐ Grandparent ☐ Child
☐ Spouse ☐ Relative ☐ Friend ☐ Partner

Title: _____ Name: _____ _____ _____
First Name *M.I.* *Last Name*

Primary Email: _____

Home: (_____) _____ - _____ Work: (_____) _____ - _____ Cell: (_____) _____ - _____

DOCTOR INFORMATION

Family Physician: _____

Name of Doctor's Office: _____

Address: _____ Suite: _____

City: _____ State: _____ Zip: _____

Office: (_____) _____ - _____ Fax: (_____) _____ - _____

INSURANCE INFORMATION

Bring client insurance card and a photo ID with you.

Primary Insurance: _____ Secondary Insurance: _____

CLIENT AGREEMENT

I understand that I am responsible for all charges rendered to me by the staff at the Auditory-Verbal Center, including any co-payments, deductibles, or co-insurance not covered by my insurance carrier. Any referrals or authorizations required by my insurance carrier should be presented to the Auditory-Verbal Center at the time of my visit or prior to my appointment. If a valid referral is not obtained prior to my appointment, fees for services rendered are my responsibility. With this signature, I authorize the Auditory-Verbal Center to release any information concerning my healthcare, advice and treatment. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the Auditory-Verbal Center. If my insurance company(ies) changes at any time, I am responsible to notify this office and provide a written copy or I will be ultimately responsible for payment of fees for professional services at that time.

_____ _____ _____ / _____ / _____
Parent or Responsible Party Signature Relationship to Client Date