



**Dear Parents:**

Thank you for inquiring about **Verbal Expressions, Inc.** We are committed to providing quality speech language therapy to children with compassion and integrity in order to ensure that your child is able to communicate with the utmost potential. We want to make sure you child reaches his/her highest potential.

Let's get started!! There are a few some very important documents that are needed in order to begin our speech therapy program. This packet of information should be brought to our office on your initial visit. There is an "Client Enrollment Packet" below that must be filled out completely. The information in the packet is necessary and essential to our comprehensive evaluation of your child. Please complete each form accurately and completely.

**Before we begin our skilled speech therapy services we must have these items in for our records:**

- \***ORIGINAL RX** (it is required for proper filing with insurance or Medicaid)
- \*Permission to Evaluate and Treat
- \*Client Information Sheet
- \*Client Medical History
- \*Copy of the front/back of Insurance card (if applicable)
- \*Copy of the front/back of Medicaid Card (if applicable)
- \*Financial Policy
- \*Release of Medical Information Form
- \*Signed HIPPA compliance form

**Please understand that therapy WILL NOT begin without the completion of these forms.**

Please contact us at (404) 297-5888 if you have any questions or concerns.

Thank You Very Much!

**Verbal Expressions, Inc.**



Client Information

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City \_\_\_\_\_ State: \_\_\_\_\_  
Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Parent/Guardian Name: \_\_\_\_\_ Cell  
Phone: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Work  
Phone: \_\_\_\_\_  
Referring  
Pediatrician \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone \_\_\_\_\_  
Reason for Referral: \_\_\_\_\_

Insurance Information: Please check and complete all that applies along with your insurance card

Private Pay (we accept cash, money order, credit cards or personal checks)  
 Insurance Carrier \_\_\_\_\_

HMO  PPO  POS  other (specify) \_\_\_\_\_

Billing

Address: \_\_\_\_\_

Billing

Phone: \_\_\_\_\_

Insured's

Name: \_\_\_\_\_

Insured

SSN: \_\_\_\_\_

Member ID# \_\_\_\_\_ Group

# \_\_\_\_\_

Babies Can't Wait (BCW)  
Cost Participation: \_\_\_\_\_ %  
Service

Coordinator: \_\_\_\_\_ Phone: \_\_\_\_\_

here \_\_\_\_\_ Medicaid (list the number

Peachstate  Ameergroup  Wellcare