FOLDER CHECK LIST

Date: _____

Client's Name: _____

Parent's/Guardian's Name: _____

DOB: _____ Age: _____ SSN # _____ Female / Male

Address: _____

_____

Telephone Number: (H) _____ (W) _____

(Cell)_____

Email Address: _____

Insurance Provider: _____

Insurance # _____ Group # _____ Contact # _____

Payment Method: _____

Referring Physician: _____

_____

Reason for Referral: _____

Have Referral in hand: _____ Referral Request needed: _____ Dr. Referral / Approval _____

Concerns/Comments: _____

_____

Follow-up Date: _____

_____

Signature of Interviewer

www.LASpeechCenter.com
Office (225) 402-4466 Fax (225) 402-4467
36505 Oak Plaza Avenue, #B
Prairieville, LA 70769

Intake Check List

O Complete Client Intake Form.

O Get Insurance verified:

_____

_____

_____

O How much therapy does the client qualify for:
How much approval time; visits/hours/sessions: _____

_____

_____

_____

O Get Insurance verified:

_____

_____

_____

O Verify the billing Code: _____

_____

_____

_____

O **Schedule Appointment** **Date: _____** **Time:_____**

_____
Signature of Interviewer

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