



*Capitol City
Speech Therapy, LLC*

141 N Main Street
Fuquay-Varina, NC 27526

3700 National Drive #219
Raleigh NC 27612.

Office: 919-577-6807 Fax: 919-577-6853
Mobile: 919-434-4596
www.capitolcityspeechtherapy.com

Name: _____ Date of Birth: _____

Address: _____ Home #: _____

_____ Cell: _____

Work: _____

Emergency: _____ Phone: _____

Contact

Food Allergies: _____

Other Allergies _____

I give permission for CCST administer: Band-aids _____

Antibacterial ointments: _____

other: _____

Child's Name: _____ DOB: _____

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I want my insurance to be billed for Speech/OT/PT services: Yes/No _____
initials

Name of Primary Insurance: _____

Policy Number: _____ Group Number: _____

Claims Address: _____

Phone number for Benefits/Eligibility: _____

Name of Policy Holder: _____ DOB: _____

Name of Secondary Insurance: _____

Policy Number: _____ Group Number: _____

Claims Address: _____

Phone number for Benefits/Eligibility: _____

Name of Policy Holder: _____ DOB: _____

By signing below, I acknowledge that all information above is accurate and correct and will inform Capitol City Speech
Speech Therapy if any information changes. I agree to pay the non refundable registration fee when form is submitted.

