

APPENDIX I

CENTER FOR COMMUNICATION DISORDERS  
Davis Hall 012

Diagnostic Billing

Billing Address: \_\_\_\_\_ Client: \_\_\_\_\_  
 Name \_\_\_\_\_ Name \_\_\_\_\_  
 Address \_\_\_\_\_ Age \_\_\_\_\_ D.O.B. \_\_\_\_\_  
 \_\_\_\_\_ Clinician \_\_\_\_\_  
 \_\_\_\_\_ Supervisor \_\_\_\_\_  
 \_\_\_\_\_ Date \_\_\_\_\_

FOR PROFESSIONAL SERVICES:

Area of Concern (Circle One):

Accent Reduction    Aphasia    Articulation/Phonology    Aural Rehab.    AAC    Auditory Proc.  
 Language    Fluency    Hearing Imp    TBI    Adult Language (other)    Voice    Other \_\_\_\_\_

Evaluation Service (Check one):

( ) Speech-Language Evaluation .....\$50.00  
 ( ) Subsequent Speech-Language Evaluation .....\$30.00  
 ( ) Other \_\_\_\_\_ .....\$\_\_\_\_\_

TOTAL .....\$\_\_\_\_\_

AMOUNT PAID .....\$\_\_\_\_\_

PAYMENT TYPE (Circle One): Cash    Check    Visa    Master Card    Discover

BALANCE DUE .....\$\_\_\_\_\_

Make checks payable to Southern Connecticut State University