Southern Connecticut State University
Department of Communication Disorders
CENTER FOR COMMUNICATION DISORDERS
Davis Hall 012

Speech-Language Pathology Diagnostic Billing

Client: _____ D.O.B: ____/_____/_____
Address: _____
City: _____State:_____Zip Code: _____
Telephone: (_____)_____e-mail: _____

Person or Agency Responsible for Payment: _____
Address: _____
City: _____State:_____Zip Code: _____
Telephone: (_____)_____e-mail: _____

Appointment Date: ____/_____/_____ **Appointment Duration** (minutes): _____

Clinician(s): _____ Instructor: _____

Area of Concern (Circle One):

Accent Reduction Aphasia Adult Language (other) Articulation/Phonology Aural Rehab. AAC Swallowing Child/Teen Language Fluency TBI Voice Other _____

Evaluation Service (Check One):

( ) Speech-Language Evaluation $100.00

( ) Subsequent Speech-Language Evaluation (within 6 months).....$50.00

( ) Other _____ .....$____

TOTAL $____

AMOUNT PAID $____

BALANCE DUE $____

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

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Please make checks payable to **Southern Connecticut State University**