Ande Ekstam, LLC
Speech-Language Pathologist
www.AndeEkstam.com

Client Registration Form

<table>
<tr><td>Client Name:</td><td colspan="2">DOB:</td><td>Today's Date:</td></tr>
<tr><td colspan="2">Race: (Caucasian, Hispanic, Asian, etc.)</td><td colspan="2"></td></tr>
<tr><td colspan="2">Guardian Information(1) - Name:</td><td colspan="2">Relationship:</td></tr>
<tr><td>Home Phone:</td><td>Cell Phone:</td><td colspan="2">Email:</td></tr>
<tr><td colspan="2">Guardian Information (2): - Name:</td><td colspan="2">Relationship:</td></tr>
<tr><td>Home Phone:</td><td>Cell Phone:</td><td colspan="2">Email:</td></tr>
<tr><td colspan="2">Street Address: <u>Must be complete</u>:</td><td colspan="2">Mailing Address <u>if different</u>:</td></tr>
<tr><td colspan="2">Primary Care Physician:</td><td colspan="2">ICD-9 (if known):</td></tr>
<tr><td>Phone:</td><td>Fax:</td><td colspan="2">Referred By:</td></tr>
<tr><td colspan="4">Insurance Information</td></tr>
<tr><td>Primary Insurance Name:</td><td colspan="2">Address:</td><td>Phone:</td></tr>
<tr><td>Name of Insured:</td><td>Relationship:
DOB:</td><td>I.D. No.</td><td>Group No.</td></tr>
</table>

Terms/Conditions for Services

I hereby authorize Andrea Ekstam, LLC, to release and/or obtain information concerning the patient's present condition with the above named insurance company. The undersigned authorizes the release of any information relating to all claims for benefits submitted on my behalf and/or my dependents through a billing service. I further agree and acknowledge that my signature on this document authorizes Andrea Ekstam, LLC, to submit claims for benefits and for services rendered without obtaining my signature on each and every claim.

______________________________________ ___________/______/___________

Client or Guarantor **Date**

Please return by email or fax to **612-437-4595**