RETURN TO _____ UNIT MEDICAL REC. NO. _____

ADDRESS _____

APPLICATION FOR TREATMENT
SCOTTISH RITE SPEECH AND LANGUAGE CLINIC

APPLICATION NO. _____ Date Received _____ Date of Clinic Visit _____
(to be recorded by hospital personnel only)

SECTION I

1. Name of Child _____
last first middle

2. Residence of Child _____
street no. street city/town state/province zip

_____
county area code phone no.

3. Age: _____ Sex _____ Birth Date _____
month day year

4. Child's Social Security No. (if available) _____

5. Name of Father _____ Age _____
first middle last

Address _____
street no. street city/town state/province zip

_____
area code phone no.

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced or Widowed

6. Name of Mother _____ Age _____
first middle last maiden

Address _____
street no. street city/town state/province zip

_____
area code phone no.

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced or Widowed

7. Name of Legal Guardian if different from above: _____ Age _____

Address _____
street no. street city/town state/province zip

_____
area code phone no.

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced or Widowed

8. Nature of Disorder _____

_____

_____

9. Has previous treatment been received from Scottish Rite Clinic? ❑ Yes ❑ No

If "yes", give name of Clinic and approximate date of application _____

If child is presently under doctor's care, please have him/her complete Section V of this form. If the child is not presently under doctor's care, give name, address and telephone number of physician who last treated the child:

_____

Physician's Name Address Phone

SECTION II

THIS SECTION TO BE COMPLETED BY APPLICANT'S PARENTS OR LEGAL GUARDIAN

1. Number of dependent children _____ Ages _____

	Father/Legal Guardian	Mother
2. Name of Employer	_____	_____
3. Address of Employer	_____	_____
4. Date Employed	_____	_____
5. Exact kind of work: (check one)	_____ Full Time ❑ Part Time ❑	_____ Full Time ❑ Part Time ❑
6. Present take-home pay in each check	$ _____ Weekly ❑ Bi-Monthly ❑	$ _____ Weekly ❑ Bi-Monthly ❑
7. Give yearly income from any other source	$ _____	$ _____
Indicate Source	_____	_____
8. Total taxable income according to last year's tax return	$ _____	$ _____
9. Previous Employer	_____	_____
10. How long employed	_____	_____
11. Previous Salary	$ _____	$ _____

12. List assets of both parents or legal guardian (excluding home and automobile): _____

_____

13. Do you rent your principal residence? _____ Monthly rental payment $ _____

14. Do you own your own home? _____ Monthly mortgage payment $ _____

15. Is this child covered by medical or hospitalization insurance? Yes ❑ No ❑

16. If there is coverage by both parents' employers, indicate both companies.

a. Father's insurance company: Name of company _____

Policy number _____

b. Mother's insurance company: Name of company _____

Policy number _____

17. Do you presently owe for any medical treatment for this child not covered by insurance? Yes ❑ No ❑

Indicate amount: $ _____

18. Have there been any other medical bills in family recently? Yes ❑ No ❑

19. Remarks _____

_____

_____

_____

_____

_____

_____ _____ _____

Signature of Father | Signature of Mother | Signature of Legal Guardian (if other than parents)

SECTION III

1. Name of Child _____

2. Residence of Child _____
   street no. street city/town state/province zip

   _____
   area code phone no.

CONDITIONS OF APPLICATION
PARENTS OR LEGAL GUARDIAN - READ CAREFULLY

Application is hereby made for the treatment of the above-named child through the Scottish Rite Foundation. Acceptance of the child for examination, treatment or care is upon the conditions, and with the consents, in this application stated.

I hereby agree as follows:

a. To deliver the child to the clinic when requested to do so, and to come for the child immediately upon being notified by the Clinic authorities;
b. To waive and relinquish any and all claims or liabilities against the Clinics, their associated, affiliated, appendant or parent corporations, and any Scottish Rite Body, or member, or the Club, or Scottish Rite Mason, arising out of or in anywise connected with the transportation of said child, his family or guardian, from one place to another, by whatsoever means, in connection with any examination, treatment or care of said child: and to indemnify such persons, firms or corporations against all loss, cost or expense resulting to any said parties in account of any claim by me or said child.

Further, in connection with the treatment or care of said child, I hereby consent and authorize:

1. Such clinic care encompassing routine diagnostic treatment, including outpatient care as the Chief of Staff or his assistants or designees shall in their judgment deem necessary;
2. In the event of an emergency, that the child may be transferred by the clinic authorities to any other clinic or facility for care or treatment;
3. Photographing or televising, and the use, publication, and distribution thereof, of the child's condition, operations or procedures to be performed, or the results accomplished, including appropriate portions of the child's body, for medical, clinical, scientific or educational purposes, provided the child's identity is not revealed unless expressly authorized in writing; and
4. That information as to diagnosis and treatment be provided to referring physician.

ALTERING THIS APPLICATION IN ANY WAY WILL RESULT IN DISAPPROVAL

Signed: _____ (Father)

Signed: _____ (Mother)

Signed: _____
(Legal guardian or other person or institutional authority legally in control of child)

Witnessed by:

_____ Date _____

(NOTE: if a person other than the parents sign this application, or if the parents are divorced, legal guardianship or control of this child must be established with custodial papers or other appropriate legal documents establishing authority to sign the application.)

CERTIFICATE OF SCOTTISH RITE MASON

SECTION IV

Remarks _____

_____

I certify that to the best of my knowledge and belief, it is financially difficult for the family of this child to afford the type of treatment and care which can be provided by The Scottish Rite Foundation. The parents have been requested to send a copy of last year's income tax form with this application.

Signature _____
Member's signature in ink Member's name - print or type

Address _____
street no. street city/town state/province zip

_____
area code phone no.

PHYSICIAN'S CERTIFICATE

SECTION V

Date _____

1. Patient's Name _____ Age _____
2. Describe the disease or disability _____
3. Do you know of any previous treatment patient has received for this condition? _____ Describe _____
4. Developmental age of child _____
5. Remarks and recommendations _____
6. Physician's Name (please print) _____
7. Physician's Address _____
   street city state zip
8. _____ M.D.
   Signature of Physician

TO BE COMPLETED AT THE CLINIC

SECTION VI

Clinical Recommendation _____

Date _____ _____ M.D.
Signature of Chief of Staff

ACTION OF BOARD

SECTION VII

Date _____ Approved _____ Disapproved _____

Reason if disapproved: _____

Signature _____