CLIENT INFORMATION

Patient: ____ DOB: __________ Sponsor's SSN: __________
Last First Middle
Address: ____
Street City ZIP

Parent/Guardian Information (if applicable)

Name: ____ DOB: ________________
Last First Middle
Address: ____
Street City ZIP

Cell Phone: __________________________ Text: Y or N Email:______________________________

Name: ____ DOB: _________________
Last First Middle
Address: ____
Street City ZIP
Cell Phone: ___________________________________ Text: Y or N Email: ______________________

Spouse/partner's name: __________________________
Occupation, specifically (a) employer, (b) title, (c) primary roles and responsibilities, and (d) how your current cognitive-communication skill, such as hindered memory, is currently impacting work: ______
____
____
If retired, when/from what:_________________________ Home phone:__________________________

Daytime phone:_____________________________ Cell Phone:_____________________________

Are you: single ☐ married ☐ divorced ☐ widowed ☐

Children (names, gender, ages): ____
____
____

Who lives in your home with you? ____

____

____

Physician

Primary Care Physician: ______________________________ Phone: _______________________
Referring Physician: _________________________________ Phone: _______________________

Insurance Information
Patient Name: ________________________________ Date of Birth: _______________

Insurance

Primary Insured: ____________________________________ DOB: ________________________

Primary Insurance Carrier: _________________________ Phone Number: ______________________

Billing Claim Address: ________________________ City: __________________ State: ____________

ID #: ____________________________________Group #: ________________________________

Secondary Insurance: ____

Policyholder Name: ____ DOB: ______________

Phone Number: _____________________________ Billing/Claim Address: ____________________

City: _________________________ State: ______________________ ZIP: ____________________

Policy Group #: _____________________________ Group #: _______________________________

Assignment of Benefits (insurance patients only):
I ______________________________________ , authorize the release of any payment and medical information necessary to process me or my family member's insurance claim and related claims. I hereby authorize payment directly to The Speech House of the insurance benefits otherwise payable to me for all professional services.

Signature of Responsible Party: _________________________________Date: _________________

Payment Contract
Under your health plan, you are financially responsible for co-payments, co-insurance or deductibles for covered services. You acknowledge that you have been told in advance by your provider that the services/products listed: Speech or Occupation therapy, may or may not be covered by your Health Plan. You agree to pay for any non-covered services.
Responsible Party: ______________________________
Relationship Party: Self______________ Parent_____________ Other(specify)______________

Signature: _____________________________________

POLICIES AND PROCEDURES

FLEX SCHEDULE

TSH is committed to providing all our clients with exceptional and consistent care. We believe that your commitment to your child's therapy schedule is essential to their progress and ultimate development. We thank you in advance for your cooperation and attention to our attendance policy. Helping your child to reach their maximum potential and making everyday differences in their lives is our privilege! Cancellations, late cancellations, and no shows compromise your child's progress and prevent another child from receiving services that day. **Please call/text the office at 573-336-1970 by 3:00 p.m. on the day before your scheduled appointment to notify us of any changes or cancellations.**

Flex Schedule allows more flexibility for our families whose schedules change week to week or due to medical appointments or other circumstances, regular appointment times/days are challenging. When om the Flex Schedule, there is no guarantee of availability of one particular therapist, specific time, or day. Please let us know if the flex schedule works better for your family. We re-evaluate monthly for continuing/discontinuing flex schedule within staff/with family.

You will be changed to a flex schedule for the following reasons:

Late Cancellations: More than 3 appointments per 3 months cancelled after 3:00 p.m. the day prior to your child's appointment.

Chronic Cancellations: Attendance at less than 80% of scheduled appointments.

Additional Attendance Policies

Vacation: Appointment time not held for more than 2 weeks.

Unexcused Absences of 2 weeks or greater: a new order may be needed, and the appointment time is no longer held.

HEALTH POLICY

Help and cooperation is required to maintain a healthy environment. You must be temperature-free for 24 hours before returning to therapy. If you have experienced vomiting and/or diarrhea, you should not return to therapy until 24 hours have passed since the last episode of the same.

Please do not bring sick or febrile family members to the clinic.

You will not be seen if any of the following is present: Too ill or uncomfortable to function in the therapy setting, continual runny nose; thick or discolored nasal discharge; excessive sneezing or coughing and mucus-producing cough; an elevated temperature.

Strict CDC guidelines are followed for COVID-19.

TELETHERAPY

Teletherapy services are offered for both children and adults. It is used as a primary service mode as well as a substitute when clinic visits are not possible due to various factors, including but not limited to inclement weather, unexpected change to your work schedule, transportation difficulty and illness (quarantine).

HEALTH INSURANCE

We participate with some insurance companies, but not all. If The Speech House is not contracted with your insurance, we will be happy to provide you with a superbill to assist you in seeking reimbursement for out-of-network provider services. Please also be advised that many health insurance plans have limited coverage for therapy services. We recommend that you contact your insurance company to discuss the limits of your coverage.

FEES

The person who completes the **Party Responsible for Payment** section is responsible for payment of all services rendered. Payment is due at the time services are rendered unless you have made other arrangements in advance. **Accounts more than 30 days overdue will be subject to a $20.00 late fee and 5% interest charge. Accounts more than 90 days overdue will be sent to collections**. For clients seeking insurance reimbursement, please be aware that **you are ultimately responsible for the payment of services rendered. If your insurance carrier denies payment (including recoupment) the client will be responsible for payment of all services rendered.**

CONSENT/PAYMENT FORM

This form must be completed before services can be initiated. If the client is under the age of 18 years, the form must be signed by the legal guardian.

CONSENT FOR TREATMENT

I hereby attest that I have voluntarily applied for and entered into treatment or give my consent for the minor or person under my legal guardianship, at The Speech House. I understand that I may terminate these services at any time.

TERMINATION OF SERVICES

Due to the importance of continuity of care, regular attendance to appointments is necessary. If excessive appointments are missed and/or canceled, The Speech House reserves the right to discharge services. If you do not keep your financial obligations to The Speech House and remain delinquent on your account for more than 30 days (about 4 and a half weeks), services will be suspended until payment is received. Services may also be terminated if it is determined that continued participation will be a detriment to the child or their family. The Speech Language Pathologist reserves the right and professional judgement to discontinue services.

Signature: ____________________________________-

Release of Information Form

Name: ______________________ Date of Birth: ____________

This form allows The Speech House to send and receive EVALS, reports, and other requested information, including sending claims to your insurance provider. If we do not have this form filled out, we will not be able to provide this service on the patient's behalf.

I hereby authorize any physician, clinic, hospital, institution or school to release Medical and Psychological information regarding myself to The Speech House. I understand that this information is to be used for professional purposes only and that it will be regarded as confidential. I also authorize The Speech House to contact any persons or institutions to obtain any additional information regarding myself, when necessary.

I hereby authorize The Speech House to release therapy reports regarding myself to any entity or professional associated with my care (physicians, any clinic, hospital, institution, insurance company, school, and other), with the exception of: ____.

This authorization includes release of information concerning HIV testing or treatment of AIDS, AIDS-related conditions, drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions.

I give my permission for The Speech House to photograph and/or videotape myself, and use *said* photos/videos for promotional or teaching purposes.

☐ Yes

☐ No

Signature: _________________________________

HIPAA Release of Information Authorization Form

I hereby authorize The Speech House and its affiliates, its employees and agents , the ability to send me electronic communication containing my personal health information maintained (such as information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, Member ID number, payment arrangements and balance information) except the following information about me: ____(DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY] for the purpose of helping me to resolve claims, or health benefit coverage issues, and the purpose of communication regarding plan of care. I also allow the Speech House staff members involved in the care of myself to email internally to each other and externally to other professionals involved in the care of myself. I understand that the electronic communication will be sent via an unsecure/unencrypted email network. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. I understand that I have a right to revoke this authorization by providing written notice to The Speech House. However, this authorization may not be revoked if The Speech House, its employees, or agents have acted on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign may affect my eligibility for benefits or enrollment or payment for coverage of services.

Signature: ____

Notice of Privacy Practices and Confidentiality Agreement

-This Notice describes how health information about yourself may be used and disclosed and how you can get access to this information.

The federal government has legislated the Health Information Portability and Accountability Act (HIPAA). The new rules regulate the privacy and accessibility of health information regarding your care at The Speech House. We must follow these privacy practices that are described in this notice until they are changed. You may request a copy of your notice at any time applicable by law. Any changes that will be added to this form will be available to you. You may request a copy of this at any time.

Use and Disclosure information

Treatment - We may use or disclose your health information to plan a course of treatment that includes evaluation, goals and treatment approach. At times, your medical information may be reviewed by a student intern at our facility. In addition, your medical records will be provided to your health plan and consulting physicians. Within the Speech House, your goals and data pertinent to your treatment may be discussed with others.

Payment - We may use and disclose your health information to obtain payment for services we provide to you/your family member. A bill may be sent to you or your health insurance payer. The information on the bill may obtain information that identifies you, your spouse, or your child. This information may include date of birth, diagnosis and procedures or supplies used.

Appointments -We may use or disclose your health information to provide you with appointment reminders (such as email, voicemail messages, postcards, or letters).

Check-In - Your name may be called when checking in at our desk.

Schools and Agencies - We may provide information requested regarding evaluations with other professionals. We may disclose your information to doctors and other health professionals in regard to your care with us.

Other Permitted Uses and Disclosures - We may share information with other public health authorities charged with preventing or controlling disease, injury or disability. We may need to provide medical information regarding yourself to legal/judicial/administrative and law enforcement person. We may need to send you information regarding your care or billing issues through the mail. We may also send you information about groups and programs. This information may come in a marked envelope with our address on it. We will not use or disclose your health information without your written authorization.

Confidentiality- No information regarding other patients may be shared outside the walls of The Speech House without permission.

Patient's Rights

- You have the right to view your health record and request a copy of it. There may be a copying and postage fee.
- You may request an amendment to your record. We are not required to make this change, but it will be noted in the record.
- You may restrict anything in our privacy act. We are not required to honor your request but will make all efforts to accommodate reasonable request. You may fax or mail this to us.
- Provide written authorization for uses and disclosures not otherwise permitted by law

Signature: ____

Individual Needs Assessment

Name: ________________________________

Extracurricular activities/hobbies that affect your area of concern? ___________________________
____
____

Explain the purpose of evaluation, why you are being evaluated for skilled cognitive-communication or occupational services in your own words:
____
____
____

History

Please check the following if they apply:

	Aphasia		Voice Disorder
	Apraxia of Speech		Spasmodic Dysphonia
	Dysarthria		Fluency/Stuttering
	Cognitive-Communication Deficit		Psychosocial:
	Developmental Disorder		Sleep Problems
	Neurological Disease/Disorder		Pain
	Mobility Issues		Falls

Describe your current speech, language, cognition (e.g., memory, thinking, reasoning), respiratory, swallowing, ADL, or mobility difficulties: ____
____
____
____
____

When was the problem first noticed? By whom? ____
____
____
____

What are your goals for coming to the clinic currently?

____
____
____

Medical History

Please check if any of the following apply:

	Stroke:	Date:		Hypertension		Pneumonia
	TBI:	Date:		COPD		Developmental Delay
	Diabetes			Drug Abuse		Kidney disease
	Alcohol Abuse			Dementia		Cancer
	Vascular disease			Multiple Sclerosis		Depression
	Dysphagia			Hypotension		Parkinson's Disease
	Obesity			Vision Impairment		Auditory Impairment
	Degenerative Disease			Stomach Problems		Seizures
	Heart Disease			Nicotine Use		Other:

Please check if you have difficulty with the following:

	Reading		Math
	Spelling		Handwriting
	Typing		Organizing work
	Finishing Tasks		Following Directions
	Remembering Information		Attention Span