harbor speech PATHOLOGY hope, healing and recovery

PEDIATRIC ADMISSION FORM

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____
Parent/Guardian: _____ Phone Number: _____
Parent/Guardian Employer: _____ Work Phone: _____
Parent/Guardian: _____ Phone Number: _____
Parent/Guardian Employer: _____ Work Phone: _____
Street Address: _____
City _____State _____ Zip: _____
Home Phone Number: _____ Other/Cell Phone: _____
Reminder Preference: ❑Email ❑Text message ❑None
Can we leave a detailed message on voicemail? ❑ Yes ❑ No
E-Mail Address: _____
Emergency Contact: _____ Phone:_____
Referring Physician/Primary Care: _____
What are we seeing your child for today? _____

Insurance Information: PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD/CARDS

Primary Insurance: _____ Phone: _____
ID Number: _____ Group Number: _____
Subscriber Name: _____ Date of Birth: _____
Relationship: ❑ Self - ❑ Spouse - ❑ Child

Secondary Insurance: _____ Phone: _____
ID Number: _____ Group Number: _____
Subscriber Name: _____ Date of Birth: _____
Relationship: ❑ Self - ❑ Spouse - ❑ Child

Release of benefits and information: I hereby authorize my insurance benefits be paid directly to the practitioner. I am financially responsible for any balance due. I authorize the practitioner or insurance company to release any information required for any claims.

_____ _____
Signature of Patient or Responsible Party Date

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Consent to treatment and Exchange of Information

I authorize the therapists and staff of Harbor Speech Pathology to:

1. Administer and perform evaluations and treatments as prescribed by my physician.
2. Release pertinent medical information to my physician, referring agency, insurer, and others as may be required for coordination of treatment and reimbursement of services.
3. Request and obtain medical information from my physician, other health care professionals, referring agency, and insurer as necessary to provide quality services and aid in obtaining reimbursement for treatments.
4. Take photographs and/or videos to be used for patient identification, training, and educational purposes. I understand that these images will not be used for any other reason without my explicit permission.

_____
Patient's Printed Name

_____
Signature of Patient and/or Guardian/ Responsible Party Date

_____
Printed Name of Guardian/Responsible Party Relationship to Patient

Release and Waiver of Liability

Our goal is to provide you with quality care and every opportunity to successfully meet your therapy goals. Unfortunately, accidents may happen through no intentional fault of the facility, staff, or other patients. Harbor Speech Pathology treats a large number of clients, many with complex diagnoses and behavior management needs. By signing below, you acknowledge the risks inherent with the therapeutic activities associated with helping individuals with developmental, cognitive, and/or physical disabilities and waive Harbor Speech Pathology, its staff, and affiliates from claims of liability for expenses and/or damages to personal property, personal injury, or death that may result from participation in these activities. This waiver of liability extends to any rescue operations/attempts made by the staff on the premises and/or en route to an emergency medical facility. You acknowledge that you retain general medical/health insurance to cover any such accidents in the event that they do occur.

_____
Patient's Printed Name

_____
Signature of Patient or Responsible Party Date

_____
Printed Name of Responsible Party Relationship to Patient

Welcome to Harbor Speech Pathology! We are happy to assist you with any questions you may have. Please take a few moments to read the following information.

Insurance: We accept most major insurance plans. As a courtesy to you, we will call your insurance company to verify your coverage for therapy in our office. Benefits quoted by an insurance representative are not a guarantee of payment and at times, can be quoted incorrectly. We encourage you to call your insurance company prior to your first appointment to verify that you are covered for therapy in our office.

Evaluation: Depending on age and abilities, we spend between 30 minutes and 1 hour with patients for the first appointment to determine the treatment plan and present levels of functioning. The evaluation generally involves a detailed intake, a speech and language, cognitive, voice or swallow assessment, goals and objectives to target if needed. Please understand that the unpaid balance is your responsibility.

Treatment: We are able to accommodate our patients with appointments times from 9:00 a.m. to 4:30 p.m., Monday through Thursday, and 9:00 a.m. to 12:30 p.m. on Fridays. We do our best to find a regular appointment time (weekly or bi-weekly, if desired) for each patient with one of our therapists.

Cost of Supplies: Occasionally, with your consent, we will order supplies to be used in your therapy sessions and at home. In the case that your insurance company does not cover these expenses, you will be responsible for the bill.

Financial Policy: Insurance co-pays are due at the time of service. It is the policy of our office to bill all claims to your insurance company as a courtesy to you. The responsibility for payment of your account remains with you at all times, including closed or rejected Labor and Industries claims.

Your insurance policy is a contract between you and the insurance company. In many instances your insurance will cover only a portion of the charges. You should be aware that you are responsible for the balance of your bill. If your claim is denied, you will be responsible for the entire charge. If no insurance is available, private payment is due at the time of service. We accept personal checks, all major credit cards, and cash payments.

Referrals/Prescriptions: It is Harbor Speech Pathology's policy to have a referral or prescription on file for all patients, regardless of your insurance company's requirements. It is your responsibility to obtain one from your primary care physician and make sure we have it at the time of service.

I HEREBY AGREE TO FULL RESPONSIBILITY FOR ALL EXPENSES INCURRED BY OR IN THE ACCOUNT OF _____.

I AUTHORIZE MY INSURANCE COMPANY TO PAY DIRECTLY TO HARBOR SPEECH PATHOLOGY FOR SERVICES RENDERED. I AGREE THAT I WILL PAY ANY REMAINING BALANCE NO LATER THAN 30 DAYS FOLLOWING THE INSURANCE PAYMENT.

_____ _____

Signature of Patient or Authorized Representative Date

Cancellation Policy

Dear Valued Patient,

We realize that coming to us for treatment requires a substantial investment in time on your part.

We have adequate staff on hand to allow 30-60 minutes for each appointment. This does mean that if you cancel an appointment without adequate notice, we may not be able to fill your appointment time. If you arrive late for your appointment you will miss part of your treatment for that day. If you are more than 10 minutes late, your appointment may need to be rescheduled for another day.

Please ensure that you attend all scheduled sessions unless absolutely necessary to miss. Consistent attendance is essential to your progress. Evidence of documented progress is often required by insurance carriers in order to maintain services. Therefore, if you do not maintain at least an 80% attendance rate, schedule changes and/or discontinuance of services may be discussed with you. We understand that circumstances will require an occasional absence from scheduled therapy sessions. In this case, we require that you give at least 24 hours of notice for planned absences and as much notice as possible for unexpected illnesses or emergencies. We also request that you make an attempt to reschedule missed visits whenever possible. After 3 consecutive or 5 total no-show / late cancellation visits, you are subject to be removed from the schedule in order to accommodate other patients from the waiting list.

We charge a fee of **$50.00** if an appointment is canceled without 24-hour notice. This charge is NOT covered by insurance and will be your direct responsibility. This is much less than the value of an appointment.

It is not intended to be punitive but rather to offset part of the cost of having a therapist scheduled. Thank you for your understanding with this policy as we provide you with quality services.

Sincerely,
Channa Beckman, M.A., CCC-SLP / CBIS
Harbor Speech Pathology

I have read and understand Harbor Speech Pathology’s cancellation policy.

_____ _____

Signature of Patient or Authorized Representative Date

Consent For Disclosure Written and Verbal Communication

I, _____, hereby authorize and request Harbor Speech Pathology or it's representatives to: _____release information to _____Obtain information from _____Exchange information with

the following individual(s):

_____
_____
_____
_____

Regarding: _____ DOB: _____

Information to be Released/ obtained:	YES	NO
Progress Reports	_____	_____
Evaluations of Treatment Participation	_____	_____
Medical History / Social History	_____	_____
Alcohol and Other Drug History	_____	_____
Psychological / Psychiatric Testing, Evaluation and Reports	_____	_____
Other (specify) _____	_____	_____

I understand that my records are protected under the Federal (42CFR) and State (RCW 71.05.390) Confidentiality Law and Regulations. I also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it, and that, in any event, this consent expires automatically as specified below or in 1 year without specification. The information released may be obtained via mail, telephone, fax, or in person.

Specification of the date, event, or condition upon which this consent expires:_____

_____ _____
Patient / Guardian Signature Date

_____ _____
Witness Date

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Pediatric Health and History Form

General Patient Information

Childs Name:_____ Gender:_____ Date of Birth:_____
Name of person completing the form: _____ Relationship: _____
Pediatrician: _____ Phone Number: _____
Last seen by pediatrician: _____ Next Doctor Appointment: _____
Other specialists who have worked with this child : _____
_____
Please list those living in the home (age and relationship to patient:) _____
_____
Please list principle concern in seeking this evaluation: _____
_____

Health/Developmental History

Length of Pregnancy: _____ Birth Weight: _____
List medications taken during pregnancy: _____

Please answer YES or NO to the following and give details if YES:	YES	NO
Any illnesses, injuries or complications during the pregnancy/delivery?	☐	☐
Did this child require any special attention during his or her stay in the hospital?	☐	☐
Did the pediatrician have any special concerns during their first year?	☐	☐
Is this child taking any medications?	☐	☐
Has hearing been tested? If so, please indicate results below.	☐	☐
Have P.E. Tubes been placed? If so, by whom and when?	☐	☐
Is there a family history of speech, language or learning problems?	☐	☐
Has vision been tested? If so, please include results below.	☐	☐

Details:_____
Please describe history of ear infections (number, who diagnosed, treatment): _____
_____
Please describe any illnesses this child has experienced (dates & treatment): _____
_____
Please describe any injuries or accidents this child has experienced (dates & treatment): _____
_____

Does this child have a history of problems with chewing, feeding or swallowing? (describe) _____
_____

Please note at what age this child first:
Smiled: _____ Sat alone: _____ Crawled: _____ Walked: _____
Spoke first word: _____ Drank from a cup: _____ Ate solid foods: _____ Was toilet trained: _____

Please check areas in which you have possible health or developmental concerns, and describe below:

☐ Vision ☐ Attention/concentration ☐ Diet/eating
☐ Self-help skills ☐ School achievement ☐ Hearing
☐ Behavior ☐ Physical health ☐ Eye contact
☐ Social interaction ☐ Balance and coordination ☐ Play skills
☐ Large motor skills (walking, sitting, jumping) ☐ Small motor skills (drawing, writing, object manipulation)
☐ Other:_____

Speech/Language History

What prompted your concerns regarding this child's speech and/or language development?
_____
_____
What language is spoken in the home? _____
Is your child learning more than one language, does this child use and understand both? (please describe): ____
_____

Expressive Language
At what age did this child: Babble: _____ Use single words: _____ Put two words together: _____
Use longer phrases or sentences: _____
How does this child communicate wants and needs?_____

Receptive Language/Comprehension
Do you have concerns about this child's ability to understand speech? (Please explain): _____
_____
_____
What type of directions, questions, or words can this child understand? (please give examples): _____
_____
_____

Articulation/Pronunciation

Please answer YES or No to the following and give details if YES:	YES	NO
Does this child have difficulty imitating simple sounds?	☐	☐
Does this child attempt to imitate words?	☐	☐

	YES	NO
Do you have difficulty understanding this child's speech?	☐	☐
Do strangers have difficulty understanding this child's speech?	☐	☐

Does this child experience frustration when not understood by others? ☐ ☐

Details: _____

_____

Fluency/Stuttering

When did dysfluency/stuttering first start or become noticeable?

_____

_____

Please check behaviors observed with this child:

☐Repeats part of words ☐Repeats whole words

☐Demonstrates tension in face or body ☐Excessive or unusual eye blinking

☐Excessive or unusual hand or body movements ☐Unusual changes in loudness or pitch

☐Repeats phrases ☐Prolongs certain sounds

☐Avoids eye contact ☐Avoids certain words

Details:_____

_____

Voice Quality

Please describe this child's voice quality (e.g. clear, harsh, gravely): _____

_____

Has this child seen a specialist (ENT, etc.) for voice problems? Please list doctors and recommendations:

_____

_____

_____

_____

Is the voice quality consistent or does it vary?_____

When were the concerns first noted? _____

Did symptoms develop rapidly or slowly? _____

Is there any discomfort in the throat at any time? _____

General

Please provide any additional information that you feel may be relevant to the child's speech/language difficulty. Your comments and opinions are VERY

important._____

_____

_____