

Comprehensive Speech and Therapy Center, Inc.
Client Information (Adult)

Client Full Name: _____ Date: _____

Date of Birth: ___ / ___ / ___ Age: _____ Sex: _____ Social Security # _____

Telephone: Home #: _____ Cell #: _____

Home Address: _____

City/State/Zip: _____

E-Mail: _____ Marital Status: _____

Full Name of Spouse: _____

Employment: _____ Work#: _____

Name of Person Filling Out Form If Other Than Client: _____

Relation to Client: _____

Telephone: Home# _____ Cell #: _____

Primary Care Physician: _____ Phone #: _____

Others Living in Home: _____ Receiving In Home Assistance? _____

How often? _____

WHO MAY WE CONTACT IN THE EVENT OF AN EMERGENCY?

Name: _____ Telephone #: _____

Relationship: _____

WHO MAY WE THANK FOR REFERRING YOU? _____

FINANCIAL INFORMATION:

Who is responsible for this client's bills? _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Social Security #: _____ Date of Birth: _____

Employer: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Would you like assistance in obtaining insurance reimbursement: Yes No

RELEVANT MEDICAL HISTORY:

Please check any of the following medical conditions which apply to you:

- | | | |
|--|---|---|
| <input type="checkbox"/> Depression/mental illness | <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Neurological Disease/Disorder | <input type="checkbox"/> Obesity | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Alzheimer's/Dementia | <input type="checkbox"/> Breathing Problems |
| <input type="checkbox"/> Degenerative Disease | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Fractures | <input type="checkbox"/> Falls |
| <input type="checkbox"/> Muscle/Tendon injury | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Circulation/Vascular Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Seizures/epilepsy | <input type="checkbox"/> Other: _____ |

Please provide details regarding any of the medical conditions you identified above: _____

Recent/Relevant Surgery: _____

Current Medications: _____

If applicable, please list any specialists you currently see: _____

If applicable, please list any recent x-rays, MRI's, or diagnostic tests that you have had and list results:

Contraindications/Precautions (a physician's order must include any precautions necessary for treatment):

- | | | |
|---|--|----------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Cardiac |
| <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Pacemaker or other metal implants | <input type="checkbox"/> Hip |
| <input type="checkbox"/> Braces(orthopedic) | <input type="checkbox"/> Lifting/weight limitations | |
| <input type="checkbox"/> Other: _____ | | |

RELEVANT SOCIAL HISTORY:

Employment/Work (job/school/play): _____

Work: Full Time Part Time Retired Student Unemployed

Sports/Hobbies: _____

PATIENT SUMMARY:

Please Describe your concerns: _____

Please list any illnesses, hospitalizations, or injuries that have affected/contributed to your concern:

Please describe events leading up to and following the illness: _____

Onset Date of Above: _____

What do you hope to accomplish with therapy services? _____

Please list any questions you would like to have answered: _____

SPEECH/LANGUAGE HISTORY:

Have you had speech therapy before? Yes No

Where? _____ When? _____

Results/Area of Focus: _____

Reason for Discharge: _____

Do you have hearing loss/wear hearing aides? Yes No

Do you have or have you ever had difficulty chewing and swallowing? Yes No

If yes, Please explain: _____

OCCUPATIONAL THERAPY HISTORY:

Have you had occupational therapy before? Yes No

Where? _____ When? _____

Results/Areas of Focus: _____

Reason for discharge: _____

PHYSICAL THERAPY HISTORY:

Have you had physical therapy before? Yes No

Where? _____ When? _____

Results/Areas of Focus: _____

Reason for discharge: _____

REHABILITATION INFORMATION:

Do you have any deficits from a prior illness/injury which were not resolved with prior therapy? Yes No

List: _____

Do you use any adapted equipment (reacher, etc.), orthotics/splints, or have modifications? Yes No

List: _____

Do you use any adapted devices (walker, cane, wheelchair, etc)? Yes No

Describe what daily activities, leisure activities, and/or current occupation/job duties are being affected and how? _____

Are you experiencing any pain which is new, unresolved or attributed to your reason for seeking therapy services at this time? Yes No

If yes, please explain (type/severity/location): _____

Have you fallen if the past year? Yes No How many times? _____

This information will be kept confidential and used solely for the purpose of providing the appropriate care to the client. Thank you.

Comprehensive Speech and Therapy Center, Inc.
1001 Laurence Ave. ♦ Suite B
Jackson, MI 49202
Phone: (517) 750-4777

CONSENT FOR SERVICES & PAYMENT POLICY GUIDELINES

I/ We, _____ give permission to Comprehensive Speech and Therapy Center (CSTC), Inc. to render services to _____ .

I/We agree to the following:

CANCELLATION POLICY: Appointment cancellation requires a **prompt** notification. If an appointment is missed without appropriate notification a \$25.00 "no show" fee will be assessed.

AUTHORIZATION: I/We grant permission to CSTC to interview, videotape, photograph, or record the patient for clinical, educational, professional purposes, or other as is common practice in this field.

RELEASE: I/We request rehabilitation services from CSTC and consent to the treatment ordered by my physician who monitors, approves and certifies the need for my care. I consent to the release of information and a copy of my medical records to CSTC by any health care provider where I received treatment.

SERVICES AND PAYMENT: Following the initial evaluation, CSTC will recommend the necessary frequency and duration of treatment. A written report will be provided by CSTC inclusive of a treatment plan and goals. CSTC will provide verbal and/or written update of progress and goals at no additional charge every 90 days. All fees are to be paid at the time of each visit unless prior payment arrangements have been made. Accounts which become 30 days overdue will be assessed a 1.5% fee on the outstanding balance each month.

Insurance/Secondary Payer

- As a courtesy to you and your family, we will bill your insurance company for the services rendered at our facility, if appropriate.
- To the extent necessary to determine liability for payment and to obtain reimbursement, COMPREHENSIVE SPEECH AND THERAPY CENTER, INC. may disclose portions of the patient's record including his/her clinical records to any person or corporation which is or may be liable for all or any portion of COMPREHENSIVE SPEECH AND THERAPY CENTER, INC. charges, including but not limited to insurance companies or health care service plans.
- **You are responsible for any co-pay or deductible you have at the time of service.**
- The undersigned agrees, whether he/she signs as the agent or the patient, that in consideration of the services to be provided, he/she hereby individually obligates himself/herself to pay the account of COMPREHENSIVE SPEECH AND THERAPY CENTER, INC. in accordance with its regular charges and/or as set forth by the terms of a managed care contract entered into by COMPREHENSIVE SPEECH AND THERAPY CENTER, INC.
- The undersigned authorizes whether he/she signs as agent or patient, direct payment to COMPREHENSIVE SPEECH AND THERAPY CENTER, INC. of any insurance benefits otherwise payable to the undersigned. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

- Should your insurance company fail to compensate COMPREHENSIVE SPEECH AND THERAPY CENTER, INC. within 60 days for services and/or reimbursements at a lower rate than ours, **you will be responsible, in full, for all fees and services which have been rendered.**
- The undersigned, if a Medicare patient, certifies, whether he/she signs as agent or the patient, that the information given in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.
- Should the account be referred to an attorney for collection, the undersigned shall pay actual attorney's fees and collection expense. All delinquent accounts shall bear interest at the legal rate.

The undersigned certifies that he/she has read the foregoing and is the patient or is duly authorized by the patient to execute the above and accept its terms.

Patient's Name (print) _____ Clinical Record# _____

Signature _____ Date _____

Witness _____ Date _____

If the patient did not sign this form, what is the relationship of the signer to the patient?

Reason for not signing _____

PATIENT CONSENT AND PAYMENT AUTHORIZATION

Comprehensive Speech and Therapy Center, Inc.
1001 Laurence Ave. ♦ Suite B
Jackson, MI 49202
Phone: (517) 750-4777

RELEASE OF INFORMATION

I/We, _____, authorize Comprehensive Speech and Therapy Center, Inc. to release information to physician and/or facility as listed below.

1. _____
2. _____
3. _____
4. _____

Regarding: myself my son/daughter my parent/spouse

Signature of patient, spouse, parent, legal guardian Date

Social Security #

DOB

Records may be secured from:

1. _____
2. _____
3. _____
4. _____

Signature of patient, spouse, parent, legal guardian Date

COMPREHENSIVE SPEECH AND THERAPY CENTER, INC.
1001 Laurence Ave., Suite B
Jackson MI 49202
517-750-4777

Notice of Privacy Practices (HIPPA)

This notice describes how medical information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

This notice is being provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPPA). This notice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, and healthcare operations and for other purposes that are permitted or required by law. PHI includes any of your written or oral health information including demographic data that can be used to identify you. This is PHI that is created or received by Comprehensive Speech and Language Center, Inc. (CSLC) and/or its agent.

Understanding Your Health Information

Each time you receive health related services a record is made of the treatment. Typically, this record contains your diagnosis and treatment notes. This information, often referred to as a health, treatment or medical record, serves as a:

- Basis for planning your care
- Means of communicating among the health professionals, e.g. therapists or physician who contribute to your care
- Legal document describing the care you received and
- Means by which you or a third-party payer can verify that services billed were actually provided

Your Health Information Rights

Although your health record is the physical property of CSLC, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosure of your information as provided by 45 CFR 164.522
- Receive confidential communications of protected health information as provided by 45 CFR 164.522
- Inspect and copy your health record as provided for in 45 CFR 164.522
- Request to amend your health record as provided in 45 CFR 164.522
- Obtain an accounting of disclosure of your health information as provided in 45 CFR 164.522
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken
- Obtain a paper copy of the notice from CSLC upon request

The right to make a request does not guarantee it will be granted, the request may be denied based on certain situations; including, emergency treatment, disclosures to the Secretary of the Department of Health and Human Services, for example. All requests must be made in writing.

Comprehensive Speech and Language Center, Inc. Responsibilities

- Maintain the privacy of your protected health information (PHI)
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction

We will not use or disclose your health information without your authorization, except as described in this notice:

We will use your health information for treatment.

For example, information obtained by a health related services provider, e.g. primary care physician, physical therapist, audiologist, occupational therapist, speech/language pathologist, and/or psychologist, will be recorded in your record and used to determine the best plan of care for you.

We will use your Protected Health Information for payment. We may use and give your health information to electronically bill third party payers and collect payment for treatment services provided to you by a contracted agent or us.

By Signing below I acknowledge that I have reviewed the HIPPA Guidelines.

Signature

Date