ADULT CASE HISTORY

Patient's Name: _____ Birthdate: _____ □ M □ F
(First) (Middle) (Last)

Drivers License: _____State of License _____ **OR** Last 4 #'s of SSN: _____

Address: _____
(Street and Number) (City/Zip Code)

Emergency Contact: _____ Daytime Phone: _____

Address: _____

Information Provided By: _____ Daytime Phone: _____

Relationship to patient: _____ How long have you known the patient? _____

Patient's Doctor: _____ Referring Doctor: _____

Reason for Referral: _____

Describe your concerns and what you would like to accomplish with this speech-language evaluation and/or treatment?

_____

What are your special interests? _____

_____

I. FAMILY HISTORY

List ALL family members, their ages, and indicate whether they are presently in the home.

Relationship	Name	Age	In Home Yes	In Home No	Occupation	Communication Problems
Self						
Others:						

Languages spoken in the home (English, Spanish, etc.) _____

Medical Family History (Circle any that apply):
Diabetes, Seizure Disorder, Asthma, Allergies, Heart Disease, Birth Defects, Infant Death, Severe Vision or Hearing Problems, Learning Disabilities, Cancer, Mental Retardation, Nervous Breakdown, or Other (Specify)

_____

II. HEALTH HISTORY

Known Diseases/Illnesses: _____

□ Yes □ No Accidents? Age (at time of accident): _____ If yes, please explain: _____

_____

□ Yes □ No Hospitalizations? Age: _____ Reason: _____

□ Yes □ No Coordination problems? If yes, please explain: _____

□ High fevers (106° or more)? How long and how often? _____

□ Colds How often and how many? _____

□ Allergies – Food, Insect bites, Drugs, etc. If yes, please explain: _____

□ Yes □ No Head injuries Age: _____ Outcome: _____

□ Yes □ No Do you have a history of neurological problems (such as seizures, epilepsy, muscle weakness, hydrocephalus, or cerebral palsy)? If yes, please explain: _____

_____

□ Yes □ No Surgeries: Age: _____ Type: _____

List present medications (for what conditions): _____

_____

□ Yes □ No Are you on a special diet? If yes, please explain: _____

Appetite: □ Good □ Poor Explain any problems with eating/drinking: _____

□ Yes □ No Do you have any other concerns about your health? If yes, please explain: _____

_____

□ Yes □ No □ Not Sure Do you have any concerns about your hearing? If yes, please explain:

_____

□ Yes □ No □ Not Sure Do you have any concerns about your vision? If yes, please explain: _____

_____

III. OCCUPATION/WORK HISTORY

Describe: _____

_____

_____

IV. EDUCATIONAL HISTORY

Highest Degree Obtained: _____

Educational Strengths: _____

Educational Weaknesses: _____

V. PRIOR SPEECH-LANGUAGE OR SWALLOWING EVALUATION OR THERAPY HISTORY

Dates: _____

Results: _____

_____

Describe your concerns that have caused you to seek treatment. _____

_____

_____

_____

_____

What questions would you like answered today? _____

_____

_____

Is there any additional pertinent information?

_____

_____

Thank you for your patience in answering these many questions. Your information and insights are of value to us.

_____
(Signature)

_____
(Date)

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEATH INFORMATION ABOUT YOU OR YOUR FAMILY MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR FAMILY'S HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your family's health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your family's health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect 06/01/06, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you or your family for treatment and payment. For example:

Treatment: We may use or disclose your family's health information to a physician or other healthcare professional who is providing treatment to you or your family.

Payment: We may use and disclose your family's health information to obtain payment for services we provide to you or your family.

Your Authorization: Information about you and your family will not be used for research, professional education, or marketing without explicit written authorization. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your family's health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your family's health information to you, as described in the Patient Rights section of this Notice. We may disclose your family's health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose your family's health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your family's health information we will provide you with an opportunity to object to such uses or disclosures. In the extent of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your family's healthcare.

Required by Law: We may use or disclose your family's health information when we are required to do so by law. Due to the changes in privacy laws since the passing of the USA Patriot Act (H.R. 3162), your personal data may be subject to search and seizure without our knowledge or local judges permission. You may elect to share information verbally and we will keep all such knowledge confidential.

Abuse or Neglect: We may disclose your family's health information to appropriate authorities if we reasonably believe that either you or your family are a possible victim of abuse, neglect, domestic violence, or the possible victim of other crimes. We

may disclose your family's health information to the extent necessary to avert a serious threat to you or your family's health or safety, or the health or safety of others.

Appointment Reminders: We may use or disclose your family's health information to provide you with appointment reminders (such as voicemails, emails, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your family's health information, with limited exceptions. You may make a verbal or written request to obtain access to your family's health information using the contact information listed at the end of this Notice. A copy of our fee schedule is available upon request.

Restriction: You have the right to request that we place additional restrictions of our use or disclosure of your family's health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: Billing to insurance is explained in a separate form that is available upon request. Billing to a third party is explained in the fee schedule that is also available upon request.

Amendment: You have the right to request that I amend your family's health information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices just ask.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your family's health information or in response to a request you made to amend or restrict the use or disclosure of your family's health information you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. An envelope is available upon request. We support your right to the privacy of your family's health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer:	Jennifer Durham M.A., CCC-SLP
Telephone:	(541) 773-8255
Fax:	(541) 779-0164
Address:	255 Stewart Ave. Ste. 101 Medford, OR 97501

_____ _____

Signature Date

Consent to Audio/Visual Recording

Audio and video recording are often employed for analytic, diagnostic, and intervention purposes. For a more thorough analysis of the nature of the communication disorder and legal consideration, receipt and sufficiency of which is hereby acknowledged, I do hereby consent, irrevocably, to the use of audio and video recordings.

Client Name: _____

The said audio and video recordings shall remain the property of The Speech Center, Inc. and will not be shared without written consent.

_____ _____

Signature of Client, Parent, or Guardian **Date**

_____

Relationship to Child (if minor)

_____ _____

Signature of Witness **Date**

Updated 2/2012

Insurance Benefits Responsibility and Agreement Form

Dear Patient/Responsible Party:

Payment is due at the time services are rendered, unless prior arrangements have been approved in advance. We accept cash, check, CareCredit, Visa or MasterCard. Annual deductibles and co-pays must be collected according to state law.

All cancellations must be made 24 hours in advance to avoid a charge. Late cancellations will be charged a fee of $25. No-show/No-call for appointments will be charged the full session fee of $45 for group and $75 for individual sessions. Insurance companies will not reimburse for this, and so claims will not be filed. Repeated cancellation/no-shows (greater than 3) may result in discontinuation of services.

We will be happy to process your insurance claim for you. It is your responsibility to provide us with full and accurate insurance information at the time of your visit, and to update our office in the event of any changes in your insurance. **We must emphasize that our relationship is with you and not with your insurance company.** We will make an effort to be an advocate for you and will notify you of your insurance benefits prior to our first meeting. Please be advised that information given to you by us is just what was told us by your insurance company. We are not responsible for discrepancies in benefits that have been quoted or misquoted to us by your insurance company. You are ultimately responsible for knowing and keeping up to date with your insurance benefits, not us. **This includes keeping track of session limits and numbers**. We will support you in monitoring the number of allowed visits, or dollar limits according to your insurance policy, but we are not able to guarantee the accuracy. You will need to remain in regular contact with your insurance company to assure your benefits are continuing as expected. Please ask for clarification at any time. Open communication is appreciated.

Accounts have a 30-day grace period. Any account that has an unpaid balance (not counting insurance which is pending) after that date will accrue interest at a rate of 18% per annum (1.5% monthly). Unpaid balances that are over 30 days old will be charged a $10.00 fee to cover additional expenses for billing—every month. You will be billed immediately for any claims denied payment by your insurance company at which time, all the above policies apply. Unpaid and late accounts which are 90 days old or greater will be turned over to a collection agency and/or attorney for collection. Balances not paid in 60 days will result in suspension from services until balances are paid in full. In the event of insurance claims delayed greater than 60 days, such as in the case of medical claims review, account balances must be paid in full and the treatment fee must be paid at the time of service for all continued sessions. In the event that your insurance company pays on a claim, you will receive credit to your account or a refund if services have been completed.

By signing this agreement, you acknowledge that your confidentiality will be breached with the collections agency who will be getting your name, address, and any personal identifying information needed for collections. The non-prevailing party agrees to pay reasonable attorney's fees and costs as set by the court having jurisdiction, including cost in any appellate court. Finally, returned checks (for any reason) will be assessed a $25.00 NSF fee. You will be required to pay this charge as allowed by Oregon Law in order to clear your record with our office. Partial payments are not acceptable on returned checks. Your understanding is greatly appreciated.

TO BE FILLED OUT BY PERSON FINANCIALLY RESPONSIBLE FOR THE ACCOUNT:

Full Name_____ Employer_____

Address_____

Social Security #_____ Insurance Co._____

Signature_____ Date_____ Phone_____

RELEASE OF INFORMATION

Client Name: _____ **Birthdate:** _____

I. I authorize the exchange of information and documentation between The Speech Center providers regarding myself/my child's treatment.

X Signature: _____ ***Date***: _____

II. I also authorize the exchange of information and documentation relating to me / my child to/from the following entities. This information will be used for professional purposes only and will not be divulged to any outside sources without expressed written permission.

Primary Care Physician(s): (required in order to obtain Rx)

Name: _____

Company: _____

Address: _____

_____

Phone: _____

X Signature: _____

Date: _____

Other entities:

Name: _____

Company: _____

Address: _____

_____

Phone: _____

X Signature: _____

Date: _____

Name: _____

Company: _____

Address: _____

_____

Phone: _____

X Signature: _____

Date: _____

Name: _____

Company: _____

Address: _____

_____

Phone: _____

X Signature: _____

Date: _____

Assignment and Explanation of Insurance Benefits

Patient: _____ **DOB:** _____

As a courtesy we are happy to verify your insurance benefits. Please understand that a quote of benefits is not a guarantee of payment from your insurance company.

Most carriers will not pre-approve visits and will only decide on coverage once they receive a claim. We request YOU contact your insurance company to review your coverage.

I authorize The Speech Center Plus to furnish my insurance company with any and all information requested concerning my claim. I hereby authorize The Speech Center Plus to bill my insurance company and to accept payment from the company on my behalf for all services, from time to time, relating to my care.

X Signature: _____ **Date:** _____
(Responsible Party / Insured)

Insurance Company: _____ Insured: _____

Address: _____

Phone: _____ Ins. ID#: _____ Group#: _____

Benefits as quoted by your insurance company upon our inquiry:

Date Benefits Quoted: _____ In Network: ☐ Yes ☐ No Benefit Limit per Calendar Year: _____

- Yearly Deductible is: $_____ ☐ Met ☐ Not Met ☐ N/A
  - Met to date: $_____
- Stop/Loss or Max out of Pocket is: $_____ ☐ Met ☐ Not Met ☐ N/A
  - Met to date: $_____

Insurance Pays _____**%** **Patient Pays** _____**%**

Services *likely* to be: ☐ Covered ☐ Not Covered

Policy Limitations and/or Exclusions: _____

_____

_____

When calling your insurance company to verify your benefits ask about:
"Outpatient speech therapy"