Greenville Speech & Language Therapy, PLLC

ADULT PATIENT REGISTRATION FORM

18 YEARS AND OLDER

PATIENT INFORMATION DATE:

PATIENT'S NAME: _____

DATE OF BIRTH: _____-_____-_____ SEX: MALE FEMALE SS#:_____-_____-_____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EMPLOYED: _____ RETIRED: _____

DIAGNOSIS: _____ ANY KNOWN ALLERGIES: _____

HOW DID YOU HEAR ABOUT US? Dr._____Website_ _____Friend_____Phonebook_____Ad_____Other_____

FAMILY/LEGAL GUARDIAN

NAME: _____ RELATION TO PATIENT: _____

ADDRESS:_____ CITY:_ _____ STATE:_ _____ ZIP:_____

PRIMARY PHONE: (____) _____ ADDITIONAL PHONE: (____)_____

SS#:_____-_____-_____ EMAIL ADDRESS:_____

NAME: _____ RELATION TO PATIENT: _____

ADDRESS:_____CITY:_____STATE:_ _____ZIP:_____

PRIMARY PHONE: (____)_____ ADDITIONAL PHONE:(____)_____

SS#:_____-_____-_____ EMAIL ADDRESS:__ _____

PATIENT'S PRIMARY PHYSICIAN

PHYSICIAN NAME: _____

ADDRESS: _____ CITY:_ _____ STATE:_ _____ ZIP:_____

PHONE :(_____) _____ FAX :(_____) _____

2856 Highway 380; Greenville, TX 75401

Phone: (903) 454-1650 Fax: (903) 454-2460

greenvillespeechandlanguage.com info@greenvillespeechandlanguage.com

PATIENT NAME: DATE:

INSURANCE INFORMATION

INSURED PERSON'S NAME:_____ DATE OF BIRTH:_____-_____-_____

HEALTH INSURANCE :_____PHONE NUMBER:(____)_____-_____

GROUP NUMBER:_____POLICY NUMBER: _____

SECONDARY INSURANCE:_____PHONE NUMBER: (___)_____-_____

GROUP NUMBER:_____POLICY NUMBER: _____

FINANCIAL RESPONSIBILITY

AUTHORIZED PERSON'S SIGNATURE:
I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature:_____Date:_____
(Patient/Legal Guardian)

RELEASE OF RECORDS

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I hereby authorize the release of any necessary information to process insurance claims, including medical and billing information, to/from Greenville Speech & Language Therapy, PLLC from/to the referring physician and insurance company.

Signature: Date:_____ (Patient/Legal Guardian)

AUTHORIZATIONS and ACKNOWLEDGEMENTS

HIPAA: Notice of Privacy Practice
By signing this statement you are acknowledging that you have had the opportunity to receive Greenville Speech & Language Therapy PLLC, HIPAA Notice of Privacy Practices:

Printed Name:_____

Signature:_____Date:_____
(Patient/Legal Guardian)

2856 Highway 380; Greenville, TX 75401
Phone: (903) 454-1650 Fax: (903) 454-2460
greenvillespeechandlanguage.com info@greenvillespeechandlanguage.com

POLICY STATEMENT

1. **Payment for therapy is due at the beginning of the scheduled session, including co-pays.**
2. Third party reimbursement should be paid directly to parents unless the insurance carrier requires that payment be made to **Greenville Speech & Language Therapy, PLLC** directly. You are obligated to pay for all services provided on your behalf, regardless of whether or not other services are covered by your policy with your insurance carrier. You are responsible for providing the required information necessary for obtaining insurance coverage and authorization. We will be happy to assist you.
3. Regular attendance is essential for the patient's growth in therapy. Should you need to cancel a session, please call as early as possible, **and make every attempt to reschedule missed treatments.** Also, note that we do NOT follow the school calendar regarding holidays and inclement weather. You may confirm appointments with your speech therapist if you have any questions regarding your therapy schedule.
4. Each family is allowed **ONE UNEXCUSED CANCELLATION** each month. If there is more than one unexcused cancellation each month, the unexcused absence of the session will be charged at the full therapy rate.
5. Progress reports with a treatment plan are written every six months. If your insurance company requests reports at more frequent intervals, there may be additional charges.
6. We make every attempt to establish good working relationships with teachers and physicians. We do NOT attend school ARD meetings or teacher conferences.
7. The waiting area is equipped with toys, books, and magazines for you and your family to use while in the waiting area. Please keep the waiting area reasonably quiet and assist the children with cleanup.
8. Please do not allow young family members in the therapy sessions.
9. Please do not allow anyone under the age of 12 in the restroom without supervision.

I have read the above policy and agree to abide by it.

Printed Name:_____

Signature:_____ Date:_____

2856 Highway 380; Greenville, TX 75401
Phone: (903) 454-1650 Fax: (903) 454-2460
greenvillespeechandlanguage.com info@greenvillespeechandlanguage.com

POLICY STATEMENT – PATIENT COPY

1. **Payment for therapy is due at the beginning of the scheduled session, including co-pays.**
2. Third party reimbursement should be paid directly to parents unless the insurance carrier requires that payment be made to **Greenville Speech & Language Therapy, PLLC** directly. You are obligated to pay for all services provided on your behalf, regardless of whether or not other services are covered by your policy with your insurance carrier. You are responsible for providing the required information necessary for obtaining insurance coverage and authorization. We will be happy to assist you.
3. Regular attendance is essential for the patient's growth in therapy. Should you need to cancel a session, please call as early as possible, **and make every attempt to reschedule missed treatments.** Also, note that we do NOT follow the school calendar regarding holidays and inclement weather. You may confirm appointments with your speech therapist if you have any questions regarding your therapy schedule.
4. Each family is allowed **ONE UNEXCUSED CANCELLATION** each month. If there is more than one unexcused cancellation each month, the unexcused absence of the session will be charged at the full therapy rate.
5. Progress reports with a treatment plan are written every six months. If your insurance company requests reports at more frequent intervals, there may be additional charges.
6. We make every attempt to establish good working relationships with teachers and physicians. We do NOT attend school ARD meetings or teacher conferences.
7. The waiting area is equipped with toys, books, and magazines for you and your family to use while in the waiting area. Please keep the waiting area reasonably quiet and assist the children with cleanup.
8. Please do not allow young family members in the therapy sessions.
9. Please do not allow anyone under the age of 12 in the restroom without supervision.

I have read the above policy and agree to abide by it.

Printed Name:_____

Signature:_____ Date:_____

(PATIENT COPY PLEASE KEEP FOR YOUR RECORDS)

2856 Highway 380; Greenville, TX 75401
Phone: (903) 454-1650 Fax: (903) 454-2460
greenvillespeechandlanguage.com info@greenvillespeechandlanguage.com

PATIENT NAME: DATE:

MEDICAL HISTORY:

	YES	NO
Do you have difficulty with speech production of sounds in words?	____	____
Do you have difficulty speaking in sentences?	____	____
Do you have difficulty understanding others during conversation?	____	____
Do you have difficulty getting words out?	____	____
Do you have difficulty swallowing?	____	____
Do you cough during meals or snacks?	____	____
Have you ever choked?	____	____
Do you feed yourself?	____	____
Do you need supervision when eating?	____	____
Do you have allergies or asthma?	____	____
Do you wear hearing aids?	____	____

**Please use this area to comment on any of the above areas, as necessary:

_____

_____

_____

Has patient ever had Home Health Care Services? (Name of company and dates)

_____

Has patient ever had prior speech therapy? (Where and dates of service)

_____

Has patient ever been hospitalized? (Where and dates)

_____

Reason for hospitalization?

_____

List any additional illnesses, injuries and hospitalizations patient has had, including severity of illness and frequency.

_____

_____

List any medications that are taken regularly.

_____

_____

2856 Highway 380; Greenville, TX 75401

Phone: (903) 454-1650 Fax: (903) 454-2460

greenvillespeechandlanguage.com info@greenvillespeechandlanguage.com

PATIENT NAME: DATE:

List all physicians seen in the past three years.

Name: _____

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

Phone: _____ Fax: _____

Last date seen: _____ Diagnosis or Condition: _____

Name: _____

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

Phone: _____ Fax: _____

Last date seen: _____ Diagnosis or Condition: _____

Name: _____

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

Phone: _____ Fax: _____

Last date seen: _____ Diagnosis or Condition: _____

2856 Highway 380; Greenville, TX 75401
Phone: (903) 454-1650 Fax: (903) 454-2460
greenvillespeechandlanguage.com info@greenvillespeechandlanguage.com

PATIENT NAME: DATE:

PRIOR EVALUATIONS/ SPECIALISTS	YES	NO
Has patient ever been seen by OT?	____	____
Has patient ever been seen by PT?	____	____
Has patient ever been seen by another ST?	____	____
Has patient ever been seen by any other specialist?	____	____
If answered "yes" please list name(s) and date(s):	____	____

Dates of evaluation(s) and/or treatment(s):

Please add any additional comments or information that we may need to know in order to better serve the patient.

**Return this form along with copies of any previous evaluations, educational plans or other reports you would like us to consider when assessing or treating patient.

2856 Highway 380; Greenville, TX 75401
Phone: (903) 454-1650 Fax: (903) 454-2460
greenvillespeechandlanguage.com info@greenvillespeechandlanguage.com