New Patient Intake Form Speech Pathology and Occupational Therapy

Patient Legal Name:_____ Preferred Name: _____
Date Of Birth:_____ Patient is: Male / Female (circle)
Parents' Names: _____
Parents' Social Security Number: _____
Primary Mailing Address: _____
Primary Phone: _____ Secondary Phone: _____
Preferred Email: _____
Primary Care Physician: _____ Primary Care office: _____
How did you hear about our office? _____
Please list **ALL** of your insurance carriers here: Primary: _____ Secondary: _____
Tertiary: _____*note: **all** insurance **MUST** be listed in the space above, no exceptions
****Name of Policy Holder**: _____
****Policy holder's Date Of Birth**: _____ relationship to client: _____

PATIENT History (please fill out the following history on the patient who is to be seen):

Primary language spoken at Home: _____ Patient's primary language: _____
School or preschool child attends (if applicable): _____
Does you child currently have a 504 or IEP in place at school? *_____
*If yes, please attach or send a copy (or bring a copy with you) prior to evaluation
Has this child ever been seen by a speech therapist, occupational therapist or physical therapist in the past? If so please elaborate: _____
_____
Why are you coming in for an evaluation (ie- what are your primary concerns / goals for therapy regarding this child)?__
_____
_____

Please describe this child's living situation at home (who resides at home, has there been any recent changes, etc): ____
_____
_____
If this child was adopted: at what age was child adopted? _____
Is the child aware of the adoption? _____Previous home experience prior to adoption (family unit information, languages spoken, etc)_____

Developmental History: At what age (if applicable) did this child:

sit up:_____	crawl: _____	feed self (w/ fingers)_____
stand alone: _____	walked alone:_____	feed self (w/spoon):_____
said single words: _____	spoke in sentences:_____	potty trained:_____
dress self: _____	tied shoe:_____	brush teeth:_____

Is this child taking any medications? If so, please list them here: _____
_____
Does this child have any known food allergies? If so to what? _____

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Please check if any of these conditions were present during the mother's pregnancy with the child listed above:

__Illness __high blood pressure
__Injury __drug use
__bleeding __alcohol use
__anemia
__operations
__ premature delivery (birth weight and how many weeks gestation at birth:_____)

Please check if any of the following conditions were present in infancy with above named patient

__birth defect __IV antibiotics
__seizures __syndromes
__oxygen deprivation __Tube feedings
__meconium aspiration __hospitalizations
__cardiac complications __NICU admission
__jaundice and transfusion

Please check if any of these conditions were present in early childhood up to present day:

__meningitis __scarlet fever __diabetes __seizures
__lung difficulties __heart defect __tuberculosis __Cystic Fibrosis
__autism __learning disability __tonsils/adenoids removed __ear tubes placed
__allergies/asthma __Vision loss/ glasses __HIV __hearing loss
__Hepatitis exposure __TB exposure __family history of hearing loss __family history of speech delay
__family history of learning disabilities (if checked, please specify): _____
__chronic ear infections (if recent, how many in the past 12 months? _____

Please list any / all hospitalizations or surgeries here: _____
_____
_____

Please elaborate with as much detail as possible about any of the conditions checked above, or please add information if we did not ask about a specific condition this patient may suffer from (ie- specific diagnosis they currently have, etc):_____
_____
_____

Behavioral history:

Please check all that apply to this child:

__ Is social and engaging __ Plays well with others __ Is aggressive
__ Makes good eye contact with adults __ Is easy going __ Is oppositional
__ Makes good eye contact with peers __ Does well with change __ Dislikes new people/ places
__ Is well behaved __ Understands safety __ Prefers to play alone
__ Listens well __ Difficulties with attention __ Is very busy / active
__ Follows 1-step directions __ Poor coping skills __ Is unable to self-calm
__ Follows 2-step directions __ Takes turns with peers __ Sensitive to criticism
__ Has tantrums __ Quickly escalates without apparent cause

Please list any of your behavioral / social concerns: _____
_____
_____

What are some of this child's interests / favorite toys ? _____
_____

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What motivates this child? _____
How does this child play with their brothers / sisters? _____
How does this child play with kids of their own age? _____

Communication / Speech and Language developmental history:

What is this child's primary mode of communication? (ie-gesture, cry, point, talk) _____
Approximately how many words (total) does this child use? _____
Does this child have difficulty expressing his or her feelings or needs / wants, leading to frustration? _____
Does this child have difficulty with specific sounds? If yes, which sounds? _____
Does this child follow age appropriate instructions? _____
Does this child have hoarseness or trouble with frequently losing their voice? _____
Does this child stutter? If yes, does this frustrate them? _____ _____
Does this child have or ever had difficulty feeding (ie choke, cough, colic, vomiting, difficulties nursing, etc) please specify:_____
Is this child a picky eater (if yes, list likes and dislikes)? _____
Does this child drink from a straw successfully? _____
Does this child use a sippy cup? If so soft or hard spout? _____
Does your child play well with others? _____
Does your child have responsibilities at home? _____

Has your child ever suffered a traumatic experience (ie- death of a close relative, parental divorce, accidents, witness to violence, frequent moves, parental loss of a job, etc)? If yes; please describe _____
_____
_____

Behavior / Social developmental history: Please check all that apply to this child:

__ Is social and engaging
__ makes good eye contact with peers
__ Is aggressive
__ Is oppositional

If there is anything further that you would like us to know about your child that would help us in helping them, please let us know here: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list here anyone who you authorize, in addition to your PCP or referring physician, to receive a report of our findings: ____
_____
_____

HIPAA Notification: By signing below you acknowledge a copy of Palmetto SpOTs Notice of Privacy Practices was provided to you. This notice provides information about how we may use and disclose you protected information; we encourage you to review it carefully. Further information about the notice may be obtained by contacting our privacy office at admin@palmettospot.com.

Legal signature of or on behalf of patient _____ Date: _____

Please ***read***, ***initial*** and ***most importantly understand*** the following:

_____ I give permission for photos / videos of this child to be used for the purpose of treatment, education and documentation.

_____ I give permission for photos / video to be used for advertising, brochure, and / or webspace.

_____ I give permission to SpOT to correspond with legal guardians and care team via e-mail regarding treatment, documentation, and home programming. I understand that once SpOT email is sent externally, correspondence may potentially be intercepted by an outside party.

_____ I understand that ***attendance*** at my therapy sessions is ***absolutely imperative*** if my child is to make progress. ***Consistency is KEY to therapy progress!!***

_____ I understand *that* ***cancellation with less than 24 hours notice*** or *no shows* will result in a $25 no show fee per 30-minute session, and $50 no show fee per one-hour session. (This fee cannot and will not be billed to your insurance)

_____ I understand that 3 no shows will result in myself or my child being removed from the schedule and placed on the waiting list.

_____ I understand if my child has a fever or is vomiting, or has lice (or any contagious skin condition), this is an excusable absence for therapy ***if the parent contacts us as soon as possible***. We have the right to deny you child services if you bring them to therapy sick. They must be 24-hours free of fever, vomit, or lice to return to therapy.

_____ I understand I **can not leave the premises while my child is in therapy or in the waiting room**. You may return to wait in your car after your child is called back for therapy, but please leave your cell number at the front office in case of an emergency.

I have read the above attendance policy and agree to adhere to these policies. Failure to adhere to these policies will result in termination of your treatment.

Legal signature of or on behalf of patient: _____ Date: _____

Health Insurance Benefits / coverage / authorizations DISCLAIMER:

As a courtesy Palmetto SpOT (legally listed as Palmetto Hearing Care Center, LLC) will attempt to verify your health insurance benefits, and / or obtain necessary authorizations for your services. Please be aware, this is only a *Quote* of your healthcare benefits provided to us by your insurance company but is *not a guarantee of payment*. *We cannot guarantee payment or verify that definite eligibility of benefits conveyed to us or to you by your carrier will be accurate or complete. Payment of benefits are subject to all terms, conditions, limitations and exclusions of the member's contract at the time of service.* We file insurance as a courtesy to our patients.

In most cases, your insurance will only pay for services that it determines to be reasonable and necessary. Our office will make every effort to bill your insurance company in a timely manner. If your carrier determines that a particular service is not reasonable and/ or necessary, or that a particular service or diagnosis is not covered under your plan, your insurance will deny coverage for the service and the billed charges will become your responsibility.

We strongly recommend, request and encourage you to be familiar with, and verify, your own benefits with your insurance company prior to being seen in our office. Please also be aware of any deductible amounts that may interfere with your out of pocket expenses for services.

I understand that Palmetto SpOT will bill my insurance company. I understand that all co-pays are due on the date of service. I understand that I am responsible for all deductible and co-insurance amounts that will likely be billed to me after an EOB is received after services are rendered. I understand that it is my financial responsibility to pay the balance due within 30-days of receiving the bill. If my insurance company denies service, I am aware and agree that I am financially responsible for my entire balance due.

Legal signature of or on behalf of patient _____ Date :_____

I understand that if my insurance company requires a referral or pre-authorization for my visit it is my responsibility to obtain this referral from my referring physician or primary care physician prior to my appointment. If my insurance plan has a maximum benefits or limitations on number of visits allowed, I understand it is ultimately my responsibility to keep track of the number of visits permitted and the number I have used.

Legal signature of or on behalf of patient _____ Date: _____

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I understand if I have an unpaid balance to Palmetto SPOT and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.

In order for Palmetto SPOT or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Palmetto SPOT and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

Legal signature of or on behalf of patient _____ Date: _____