



New Patient Intake Form Speech Pathology and Occupational Therapy

Please fill out this form in its entirety. No exceptions:

Patient Legal Name: _____ Preferred Name: _____

Date Of Birth: _____ Patient is: Male / Female (circle)

Fathers Name: _____ Mothers Name: _____

Fathers Social Security Number: _____ Mothers Social Security Number: _____

Primary Mailing Address: _____

Fathers cell Phone: _____ Mothers cell Phone _____

Preferred Email: _____

Secondary email: _____

Emergency contact (name, email and phone number of someone not listed above): _____

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 your 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
- Injury
- bleeding
- anemia
- operations
- premature delivery (birth weight and how many weeks gestation at birth: _____)
- high blood pressure
- drug use
- alcohol use

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

- birth defect
- seizures
- oxygen deprivation
- meconium aspiration
- cardiac complications
- jaundice and transfusion
- IV antibiotics
- syndromes
- Tube feedings
- hospitalizations
- NICU admission

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

- meningitis
- lung difficulties
- autism
- allergies/asthma
- Hepatitis exposure
- family history of learning disabilities (if checked, please specify): _____
- chronic ear infections (if recent, how many in the past 12 months? _____)
- scarlet fever
- heart defect
- learning disability
- Vision loss/ glasses
- TB exposure
- diabetes
- tuberculosis
- tonsils/adenoids removed
- HIV
- family history of hearing loss
- seizures
- Cystic Fibrosis
- ear tubes placed
- hearing loss
- family history of speech delay

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

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:

- | | |
|--|--|
| <input type="checkbox"/> Is social and engaging | <input type="checkbox"/> Is aggressive |
| <input type="checkbox"/> makes good eye contact with peers | <input type="checkbox"/> 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: _____

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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) and you will be removed from the schedule if cancellation with short notice is excessive (more than three times in a three month period)

I understand that I may be removed from a therapist's schedule (for set weekly or bi-weekly repeating appointments) if I call to cancel excessively (more than three times in a 3-month period) **within 24-hours** prior to my scheduled appointment.

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, excessive cough, is vomiting, has had exposure to COVID19, is under quarantine for COVID19, 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 : _____

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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: _____

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: _____

Thank you for taking the time to fill out this paperwork! All of this information will greatly help us to help your child be his or her best!

We look forward to working with you and your child soon!

~Team SpOT



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