New Patient (ADULT VERSION) Intake Form Speech Pathology and Occupational Therapy

Patient Legal Name:_____ Preferred Name: _____
Date Of Birth:_____ Patient is Male / Female (circle)
Primary Phone: _____ Secondary Phone: _____
Preferred Email _____
Primary Care Physician: _____ Primary Care office: _____
Primary Mailing address: _____
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 beneficiary (whose name is the insurance under): _____
Beneficiary/ policy holder's Date Of Birth _____ relationship to client _____

PATIENT History

Please check all that apply and feel free to elaborate:

- Depression / mental illness _____
- Neurological disease/ disorder _____
- Heart problems _____
- Stroke / TIA _____
- Headaches _____
- Cancer _____
- Breathing problems _____
- Degenerative disease _____
- Auto accident (date of accident) _____
- Seizures / epilepsy _____
- Vision problems _____
- Head injury (date of injury) _____
- Problems chewing / swallowing _____
- Pain _____

What do you do for a living? _____

What are your hobbies? _____
_____
_____

Have you ever been seen by a speech therapist, occupational therapist or physical therapist in the past? If so please elaborate (area of focus, when were services completed, why were you discharged, etc): _____
_____
_____
_____
_____

Why are you coming in for an evaluation (ie- what are your primary concerns / goals for therapy)?_____
_____
_____
_____
_____

Primary language spoken: _____

Have you been diagnosed with a hearing loss? Yes no Do you wear hearing aids? Yes no

Have you recently been diagnosed with a specific illness that would affect your speech, language, swallowing or physical movement? If so please elaborate: _____
_____
_____
_____
_____
_____

Have you had any relevant surgeries? If so please elaborate: _____
_____
_____
_____

Are there any precautions our therapist should have while working with you? _____
_____
_____
_____

Please use this space to share any other information that may be pertinent to your case: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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

HIPPA 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 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 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 I expect 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 being removed from the schedule and placed on the waiting list.
_____ I understand if I have a fever or are vomiting, or have any contagious condition, this is an excusable absence for therapy ***if you contact us as soon as possible***. We have the right to deny you services if you attend therapy sick. You must be 24-hours free of fever, vomit, or other contagious symptoms to return to therapy.

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: _____

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: _____