Todays Date: _____

Welcome to Palmetto SpOT! ***We are excited and grateful that you have chosen us to trust in the care of yourself or a loved one. Palmetto SpOT was established in 2006 by the Bish family. We have remained to be family owned and operated proudly serving the Lowcountry, meeting and exceeding the expectations of thousands of patients.***

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 who has permission to take calls from SpOT):_____
_____
_____
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)_____

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 _____

_____

_____

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:_____

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

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

__ premature delivery (birth weight and how many weeks gestation at birth:_____)

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: _____

_____

Is this child taking any medications? If so, please list them here: _____

_____

Does this child have any known food allergies? If so to what? _____

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 ? _____
_____

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? _____

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 (if you agree)*** 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/ social media.

_____ 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 (at the discretion of the therapist and office manager).

_____ 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** *within 24-hours* prior to my scheduled appointment. A doctors note will be required for excessive 'sick' absences.

_____ I understand that 3 no shows will result in myself or my child being removed from the schedule and placed on the standby 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. ***You must be back in the building no less than 10 minutes before the end of your child's session.***

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: _____

PATIENT FINANCIAL POLICIES:

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. *Please be prepared to pay co-pays and co-insurance at the time of service. We accept VISA, Mastercard, Cash or Check. Credit card processing will incur a 4% transaction fee.*

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. If my insurance changes I must notify Palmetto SpOT immediately wither by phone or by email (admin@palmettospot.com). **Palmetto SpOT is NOT liable for services that will not be paid based on a change of insurance that we are not notified of.**

I understand that if my insurance company requires a referral or pre-authorization for my visit **it is my responsibility to obtain this referral (and confirm with the PCC staff that the referral was received)** 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.

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.

I understand that I may be liable for an outstanding balance if my insurances are not coordinated. If a representative reaches out to you, and you do not comply with what the insurance representative and / or SpOT represehtative is asking you to do on behalf of what your insurance requests, you are reliable for any amounts that are not billable based on your lack of resolve.

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.

Please print the name of the person / parent (s) financially responsible for this account:

_____

Social Security number AND birthdates of person / parent responsible for this account (commercial insurance accounts and Tricare only):

_____

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

- ***Please be aware that if you have commercial insurance, and you are being seen for Speech or Occupational Therapy evaluations, there will likely be a payment due of $165.00 for the initial evaluation. Please call our office if you have any questions.***
- ***We accept all forms of payment. Credit cards will incur a 4% convenience fee.***
- ***We require, as best practices, a referral from your primary care physician. Please be aware that they may be reaching out to verify this referral request.***

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

9730 Dorchester Road Unit 206
Summerville SC 29485
www.palmettospot.com

Phone 843-594-3032
Email: NPCC@palmettospot.com