SPEECH THERAPY SERVICES, P. C.

502 S. Wheat Avenue
Bainbridge, GA 39819
Phone-(229) 246-9891 Fax-(229) 246-0205

PATIENT INFORMATION AND CONSENT

LAST NAME______________________**FIRST NAME**____________________**M.I.**___________

HOME PHONE NUMBER:___________________ **CELL NUMBER:** _______________________

OTHER NUMBER: _____________________ **CONTACT PREFERENCE:** **CALL** ☐ **TEXT** ☐

ADDRESS:_______________________________________ **CITY:**____________ **STATE:** ______

ZIP:___________ **DATE OF BIRTH:**_____________ **DOCTOR:**____________________

SOCIAL SECURITY NUMBER:_________________________

PRIMARY INSURANCE NAME:___________________________**NUMBER:**_________________

Notice of Privacy Practices:
Speech Therapy Services, P.C. (STS) is required to provide our patients with a privacy notice regarding our legal duties and policies to protect your health privacy. Our practice is dedicated to maintaining the privacy of your individual identifiable health information (IIHI). This notice serves to inform you that STS uses your personal health information primarily for treatment, obtaining payment, and consulting with necessary health and educational members of this facility, including your doctor and his/her staff. You may obtain a complete copy of our office procedures and privacy practices at any time by contacting our office at the above location. If you have any questions or concerns, do not hesitate to call the speech therapy office at 246-4088.

Consent for Treatment and Billing:
I have read and understand the process of speech therapy services, including evaluation, treatments, attendance policies and privacy policies at STS. I give permission for STS to evaluate and provide speech therapy services to the patient listed above as indicated. I authorize the staff at STS to discuss protected health information with this patient's caregivers, physicians and insurance company as needed to ensure coordination of services and quality care. I authorize STS to follow the necessary steps to bill this patient's insurance company including the release of information to insurance providers as needed for the billing for services provided. **I understand I am responsible for all charges at the time services are rendered and if my insurance is billed, I am responsible for all unpaid balances.**

______________________________ ______________________________
Patient Signature or responsible party **Print Name**

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Bainbridge, GA 39819
229-246-4088 229-246-0205 FAX

Thank you, for choosing Speech Therapy Services, P. C. We kindly request that you fill out all the necessary information for our therapists to complete a comprehensive evaluation. Please mail this packet back prior to the evaluation, if possible, so it can be reviewed.

SPEECH ADULT – CASE HISTORY FORM

Name:____Date of Birth:________________
Address____Phone:_____________________
City, State, Zip____

Occupation:____Business Phone:______________
Employer:____

Referred by:____Phone:______________________
Address:____

Family Physician:____________________________________Phone:_____________________
Address:____

Are you: ____Single ____Widowed ____Divorced Married – Spouse's Name:____________

Children: (Include their name, gender and age)

____
____
____

Who lives in the home?

____
____

What language(s) do you speak? Which is your dominant language? ______________

____
____

What was the highest grade, diploma or degree you earned? ______________________________

GENERAL INFORMATION

Describe your speech-language problem. List current diagnosis/Current medical findings.

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____

What do you think may have caused the problem?

____
____
____
____

Has the problem changed since it was first noticed? How? ____Yes ____No

____
____
____
____

Have you seen any other speech-language specialists? ____Yes ____No
If yes, When and for how long?____
What were the conclusions or suggestions?

____
____
____
____

Have you received any speech therapy while homebound? ____Yes ____No

Have you seen any other specialist (physicians, audiologists, psychologists, neurologists, etc)?
____Yes ____No
If yes, indicate the type of specialist, when you were seen and the specialist's conclusions or suggestions.

____
____
____
____

Are there any other speech, language or hearing problems in your family? ____Yes ___No
If yes, please describe:

____
____
____
____

MEDICAL HISTORY

Provide the approximate ages at which YOU suffered the following illnesses and/or conditions:

Allergies	Asthma	Colds
Dizziness	Draining Ear	Ear Infections
Encephalitis	Headaches	Hearing Loss
High Fever	Influenza	Mastoiditis
Meningitis	Noise Exposure	Otosclerosis
Pneumonia	Seizures	Sinusitis
Tinnitus	Other	

Do you have any eating or swallowing difficulties? ____Yes ____No
If yes, please describe:

____
____
____
____

List all medications you are taking.

____
____
____
____
____

Are you having any negative reactions to these medications? ____Yes ____No
Is yes, please describe:

____
____
____
____

Describe any major surgeries, operations or hospitalizations and when they occurred.

____
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Describe any major accidents and when they occurred.

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ADDITIONAL INFORMATION

Please provide any additional information that might be helpful in the evaluation or remediation process.

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(Use a separate sheet of paper if you need additional space.)

Person completing form:____

Relationship to patient:____

Signature:____

Please return this packet of information by mail prior to the evaluation, if possible, so the therapists can review and prepare the necessary evaluation. If it is not possible to return these prior to the evaluation, please bring them with you on the day of the evaluation.

On the day of the evaluation, you will need:

- ✓ Insurance information
- ✓ Prescription from the physician ordering the therapy evaluation (if MD did not fax it directly to Speech Therapy Services.)
- ✓ Copy of any evaluations done by specialists (psychologist, neurologist, etc.)

Thank you for taking the time to fill out this important information. Please mail it back to us as soon as possible to the address at the top of Page 1.

If it is not possible to mail this form, please be sure to bring it with you to the evaluation.