Greenville Speech & Language Therapy, PLLC

PATIENT REGISTRATION FORM FOR 18 YEARS & YOUNGER

PATIENT INFORMATION DATE:

PATIENT'S NAME:_____

DATE OF BIRTH: _____-_____-_____ SEX: MALE FEMALE SS#:_____-_____-_____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SCHOOL: _____ GRADE/CLASS: _____

DIAGNOSIS: _____ ANY KNOWN ALLERGIES:_____

HOW DID YOU HEAR ABOUT US? Dr._____Website_____Friend_____Phonebook_____Ad_____Other_____

FAMILY/LEGAL GUARDIAN

NAME: _____ RELATION TO PATIENT: _____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

PRIMARY PHONE: (____) _____ ADDITIONAL PHONE: (____)_____

SS#:_____-_____-_____ EMAIL ADDRESS:_____

NAME: _____ RELATION TO PATIENT:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

PRIMARY PHONE: (____)_____ ADDITIONAL PHONE:(____)_____

SS#:_____-_____-_____ EMAIL ADDRESS:_____

PATIENT'S PRIMARY PHYSICIAN

PHYSICIAN NAME: _____

ADDRESS: _____ CITY:_____ STATE:_____ ZIP:_____

PHONE :(_____) _____ FAX :(_____) _____

2856 Hwy 380 Greenville, TX 75401

phone: (903) 454-1650 fax: (903) 454-2460

greenvillespeechandlanguage.com info@greenvillespeechandlanguage.com

PATIENT NAME: DATE:

INSURANCE INFORMATION

INSURED PERSON'S NAME:_____ DATE OF BIRTH: _____-_____-_____

HEALTH INSURANCE PROVIDER:_____PHONE NUMBER:(____)_____-_____

GROUP NUMBER:_____ POLICY NUMBER: _____

SECONDARY INSURANCE:_____ PHONE NUMBER:_____

GROUP NUMBER:_____ POLICY NUMBER:_____

FINANCIAL RESPONSIBILITY

AUTHORIZED PERSON'S SIGNATURE:
I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature:_____ Date:_____
(Patient/Legal Guardian)

RELEASE OF RECORDS

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I hereby authorize the release of any necessary information to process insurance claims, including medical and billing information, to/from Greenville Speech & Language Therapy, PLLC from/to the referring physician and insurance company.

Signature:_____Date:_____
(Patient/Legal Guardian)

AUTHORIZATIONS and ACKNOWLEDGEMENTS

HIPAA: Notice of Privacy Practice
By signing this statement you are acknowledging that you have had the opportunity to receive Greenville Speech & Language Therapy, PLLC HIPAA Notice of Privacy Practices:

Printed Name:_____

Signature:_____Date:_____
(Patient/Legal Guardian)

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POLICY STATEMENT

1. **Payment for therapy is due at the beginning of the scheduled session.**
2. Third party reimbursement should be paid directly to parents unless the insurance carrier requires that payment be made to **Greenville Speech & Language Therapy, PLLC** directly. You are obligated to pay us for all services provided on your behalf, regardless of whether or not other services are covered by your policy with your insurance carrier. You are responsible for providing the required information necessary for obtaining insurance coverage and authorization. We will be happy to assist you.
3. Regular attendance is essential of the patient's growth in therapy. However, should you need to cancel a session, please do so as soon as possible. **Please make every attempt to reschedule missed sessions.** Also, note that we do NOT follow the school calendar regarding holidays and inclement weather. You may confirm appointments with your therapist if you have any questions regarding your therapy schedule.
4. Each family is allowed **ONE UNEXCUSED CANCELLATION** each month. If there is more than one unexcused cancellation each month, the unexcused absence of the session will be charged at the full therapy rate.
5. Progress reports with a treatment plan and goals are written every six months. Families are billed for one hour of service for these documents. Families are billed for one-half hour of service for the initial treatment plan, which is written soon after enrollment in therapy. If your insurance company requests reports at more frequent intervals, there may be additional charges.
6. We make every attempt to establish good working relationships with schools and pediatricians. Should you wish our attendance at an IEP or a teacher conference, please make your request at least two weeks in advance so that an updated status review can be prepared. Attendance at such meetings is charged at the same rate as hourly treatment sessions.
7. The waiting area is equipped with toys, books, and magazines for you and your family to use while in therapy as well as for anyone's use while in the waiting area. Please keep the waiting area reasonably quiet and assist the children with toy cleanup.
8. Please do not allow young family members in the therapy sessions.

I have read the above policy and agree to abide by it.

Printed Name:_____

Signature:_____ Date:_____

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(PATIENT COPY PLEASE KEEP FOR YOUR RECORDS)

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PATIENT NAME: DATE:

MEDICAL HISTORY:

	YES	NO
Was mother's condition during pregnancy good to excellent?	____	____
Were medications taken during pregnancy?	____	____
Were there any complications/illnesses during pregnancy?	____	____
Was patient born within two weeks of due date?	____	____
Was patient adopted?	____	____
Were labor and delivery normal?	____	____
Was labor induced?	____	____
Was there evidence of injury or poor health at birth?	____	____
During the first month of life, was patient's health good?	____	____
Were there any feeding problems as a baby or toddler?	____	____
Was patient's activity level average as a baby and toddler?	____	____
Any allergies or are allergies suspected?	____	____
Was development of teeth normal?	____	____

**Please use this area to comment on any of the above areas, as necessary:

_____

_____

_____

Has patient had ear infections? (list frequency and severity)

_____

Has patient had hearing testing or tympanometric testing? When, where, and results?

_____

Does patient have tubes in ears? Do you have any concerns about hearing?

_____

List any additional illnesses, injuries and hospitalizations patient has had, including severity of illness and frequency. List any medications that are taken regularly.

_____

_____

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PATIENT NAME: DATE:

DEVELOPMENTAL HISTORY:

Does patient exhibit or at any time exhibited any of the following behaviors?
If so, please indicate age and any attempts to alter his behavior.

Behavior	*Age*	*Comments*
Excessive Shyness	_____	_____
Thumb/Pacifier Sucking	_____	_____
Difficulty separating from parents	_____	_____
Face Twitching	_____	_____
Strong Fears/Nightmares	_____	_____
Temper Tantrums	_____	_____
Sleep Difficulties or Bedwetting	_____	_____
Difficulty sitting still	_____	_____
Inability to complete activities	_____	_____
Attention Problems	_____	_____

Does patient play well with peers? Do you have any concerns about patient's play?

_____

_____

Describe patient's performance in the following academic areas:

Math: _____

Reading: _____

Writing: _____

Does patient enjoy school? (please comment)

_____

_____

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PATIENT NAME: DATE:

DEVELOPMENTAL MILESTONES:

When did patient first achieve the following motor milestones?
Please comment on difficulties or concerns.

Milestone	*Age*	*Comments*
Crawling	_____	_____
Sitting Unassisted	_____	_____
Walking	_____	_____
Holding a Cup	_____	_____
Using a Spoon	_____	_____
Using Crayons	_____	_____
Toilet Training	_____	_____

When did patient first exhibit the following speech/language skills?

Milestone	*Age*	*Comments*
Babbling	_____	_____
Imitating Words	_____	_____
Using first word meaningfully	_____	_____
Putting words together	_____	_____

Did patient's speech/language development seem to develop normally and then stop or regress? _____

Does (s)he understand what is said to her? _____

Does (s)he follow spoken directions? _____

Does (s)he talk in (check one) single words ____; phrases ____; complete but grammatically incorrect sentences ____; complete grammatically correct sentences ____.

Does (s)he often hesitate and/or repeat sounds and words? _____
Is his/her speech (check one) too fast _____, too slow _____, average _____?

Is his/her voice (check) too soft _____, too loud _____, average loudness _____, hoarse _____, nasal _____, denasal (stuffed as during a cold) _____, other _____?

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PATIENT NAME: DATE:

ENVIRONMENTAL HISTORY:

Names of Siblings	Birth Dates
_____	_____
_____	_____
_____	_____

Others in the Home _____

Have any other family members or relatives had the following difficulties?

Difficulty	*Yes/No*	*Relationship to Child*
Speech or Language Problem	_____	_____
Hearing Problem	_____	_____
Learning Disability	_____	_____
Reading Problem	_____	_____
Emotional Problems	_____	_____
Other	_____	_____

PRIOR EVALUATIONS/THERAPY:

Has patient been seen by any other specialists? Yes ____ No _____

Please list any specialists patient has seen for medical, developmental, or educational concerns. Please list current therapists, if any.

_____

_____

_____

_____

Please add any additional comments or information that we may need to know in order to better serve patient. Thank you.

_____

_____

_____

_____

**Please return this form along with copies of any previous evaluations, educational plans or other reports you would like us to consider when assessing or treating patient.

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