Speech Therapy Plus, pllc.
1421 FM 359, Suite H
Richmond, TX 77406
(281) 232-1900
Team@Speechtherapyplus.com

Patient Information:

Last Name: First Name: Middle Initial:

Address: Apt. #

City: State: Zip Code:

Home Phone: Work Phone:

Cell Phone: Fax:

Email Address:

Patient's Date of Birth: Parent SSN: Patient's Sex ○ M ○ F

Guarantor Name:

Primary Insurance Information:

Insurance Company:

Subscriber #: Group #:

Name of Insured: D.O.B. of Insured:

Employer of Insured: Work Phone:

Employer Address:

Work Status (Check one): ○ Full Time ○ Part Time ○ Retired ○ Unemployed

Secondary Insurance Information:

Insurance Company:

Subscriber #: Group #:

Name of Insured: D.O.B. of Insured:

Employer of Insured: Work Phone:

Address of Employer:

Work Status (Check one): ○ Full Time ○ Part Time ○ Retired ○ Unemploye

Emergency Contact Information:

Name: Relationship:

Home #: Cell #:

Address:

Did your current physician refer to you? ◯ Yes ◯ No

Current Physician:

Address:

Phone No: Fax:

If no, please provide the following information:

Name of referring Physician (if applicable):

Address of referring Physician:

Contact phone # of referring Physician:

Were you referred to us by someone else or did you hear about us from another source? If yes, please let know from where:

I authorize Speech Therapy Plus, pllc. to bill my insurance company. I understand that I am financially responsible for charges, whether or not paid for by my insurance. I hereby authorize the release of all information necessary to secure payments of benefits. I authorize the use of this signature on all insurance submissions.

Signature: Date:

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Adult Patient Medical History Form

Family Information:

Are you...? ◯ Singl ◯ Marriec ◯ Partnei ◯ Seperatec ◯ Divorced ◯ Widowec

List members of Immediate Family

Name	Age	Relationship	Health Problems

Work History:

Are you currently employed outside the home? ◯ Yes ◯ No

If not, are you ◯ Retirec ◯ Disable

Present type of work: _____

At work, are you exposed to: ☐ harmful toxins ☐ heavy lifting ☐ extreme temperatures ☐ undue stress ☐ other potential hazards

Current Medical History:

Are you having any medical problems? ◯ Ye: ◯ No

If yes, please explain _____

_____

Has your vision ever been tested?	◯ Yes	◯ No
Do you wear glasses?	◯ Yes	◯ No
Do you think you may have a vision problem?	◯ Yes	◯ No
Has your hearing ever been tested?	◯ Yes	◯ No
Do you wear a hearing aid?	◯ Yes	◯ No
Do you think you may have hearing problem?	◯ Yes	◯ No

Family History: tf patient or family member has or has had any of the following problems, mark as indicated below and explain in the space provided:

P-Patient M-Mother F-Father GM-Grandmother GF-Grandfather A-Aunt U-Uncle

chronic illness:

allergies:

speech problem:

hearing problem:

swallowing problems:

asthma/lung problems:

respiratory infections:

tuberculosis:

immunity problems/HIV:

high blood pressure:

heart attack:

intellectual disability:

drug/alcohol use:

stroke:

cancer:

seizures:

mental illness:

other:

Additional Comments:

Please list below all illnesses, injuries and operations:

1) Type: Date:
Complications: Treatment:
Physician:

2) Type: Date:
Complications: Treatment:
Physician:

3) Type: Date:

Complications: Treatment:

List all Present Physical Disabilities:

Current Medications and Purposes:

Are you allergic to any Medications? ◯ Yes ◯ No

If yes, please list medications and their reactions:

Are you allergic to any Foods? ◯ Yes ◯ No

If yes, please list foods and their reactions:

Description of Speech and/or Hearing Problems:

Check any of the following which describes difficulties you presently have:

- ☐ Often hoarse
- ☐ Voice is high pitched
- ☐ Low pitched
- ☐ Too loud
- ☐ Lacks volume
- ☐ Fast rate of speech
- ☐ Slow rate of speech
- ☐ Sounds gravelly
- ☐ Other symptomsplease explain:
- ☐ Voice tires easily
- ☐ Voice breaks
- ☐ "Lump in the Throat" feeling
- ☐ Mispronunciation
- ☐ Difficult for others to understand when you talk
- ☐ Diffieult for you to understand others' speech
- ☐ Stuttering
- ☐ Hesitant

Has anyone ever looked at your vocal cords and/or soft palate? ◯ Yes ◯ No

If yes, what was found?

Have you ever had a modified barium swallow test? ◯ Yes ◯ No

If yes, what was the results?

Check any of the following which describes difficulties you presently have:

- ☐ Feeling of food/liquid going down the wrong way
- ☐ Dfficulties with swallowing and/or chewing problem
- ☐ Difficulty initiating a swallow
- ☐ Feeling of food/liquid stuck in throat
- ☐ Require multiple swallows to clear food/liquid from throat
- ☐ Cough when eating or drinking
- ☐ Difficulty chewing or clearing food from mouth
- ☐ Sound wet/gurgle when eating or drinking
- ☐ Runny nose/watery eyes when eating or drinking
- ☐ Temperature spikes throughout the da
- ☐ Other, Please explain

Social History:

Hobbies:

Sports:

What is your primary goal to achieve through speech therapy services?

If there is any additional information that you feel would be important for your provider to be aware of, please explain:

SPEECH THERAPY PLUS, PLTC.
POLICY STATEMENT/PATIENT COPY

Please read and initial each:

1. _____ If you must **CANCEL** a session, please do so **AT LEAST 4 HOURS IN ADVANCE**, otherwise you may be charged in full for unexcused absences. **Please make every attempt to reschedule missed sessions.** Please confirm appointments with the therapist if you have any questions regarding your therapy schedule.

2. _____ Private pay and insurance co-payments are to be paid in full at the time services are received. Insurance will be billed as necessary.

3. _____ I understand that I will be responsible for any/all charges for provided services in the case that insurance claim submissions are denied for any reason.

4. _____ It is very important to arrive that you adhere to your appointment time. Late arrivals for appointments will be seen for the remaining period of time for their allotted time schedule. You will still be charged for the full scheduled time.

5. _____ If you have to drop off a patient and leave the premise for any reason, please be on time. Late arrivals may result in forfeiting the post-appointment consultation with the therapist.

6. _____ Therapy sessions include 5 minutes of consultation with the therapist following a treatments session. For example, for a 30 minute session consists of a 25 minute treatment session and then five minutes to discuss the patient's progress

7. _____ Progress reports with a treatment plan and goals are written every 12 months. The appointment length for evaluations and re-evaluations are one hour. These appointments include a written report with the treatment plan and goals. Re-Evaluation and progress reports are completed every 12 months. Your insurance company may requests reports at more frequent intervals which may result in additional charges.

8. _____ You may be asked to remain at the office while during the patient's therapy session.

9. _____ The waiting area is equipped with toys and books for everyone's use during the patient's therapy session. We ask you to please respect all the patients and therapists that are in therapy sessions by keeping the waiting area reasonably quiet

10. _____ Please do not allow siblings to accompany the patient during their therapy session.

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

_____ _____

Signature Date

_____

Acceptance: Missy McDonald

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General Consent of Treatment

I authorize Speech Therapy Plus to provide speech therapy evaluations and treatment services as long as the a therapisUpatient relationship exists or until I withdraw my consent' _____ (Please initial)

Consent for Gonsultation Services

I authorize Speech Therapy Plus, PLLC., it's provide(s) and/or other designated office staff, to share and consult with other providers (such as PCP, specialist doctors and other speech therapists) in order to allow and promote the continuity of care. _____ (Please initial).

Observation Consent

I authorize and give consent to receive treatment under the observation of a student either currently enrolled in an Occupational Therapy curriculum program or one considering an OT career. _____ (Please initial).

Consent for Voicemail and Text Notifications

As a service to our patients, Speech Therapy Plus may need to make important calls/texts regarding appointments or other speech therapy related information that may need to be place on your auto.messaging system. The information may include protected health information. By initialing thas notice, you consent to receiving such calls/ texts at the phone number you have provided to us. _____ (Please initial).

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Consent for Release of Information

I authorize Speech Therapy Plus, pllc., it's provide(s) and/or other designated office staff, to release and obtain clinical information for _____ (patient) as it relates to the treatment, authorization for treatment and for the purposes of insurance reimbursement. I understand this information may be shared with insurance companies, physicians' offices and/or other required medical/educational offices as it relates to the treatment of this patient. If you have someone that you want your information shared with, please list the name(s), relationship to you, and phone number of that person(s) here:

_____

_____ (Please initial).

Privacy Notification

I have received a copy of Speech Therapy Plus' privacy policy. I have read and understand this information as it relates to my rights and protections under the federal health information privacy law. I also understand that I may ask questions at any time regarding my privacy rights as it pertains to services provided by Speech Therapy Plus _____ (please initial).

I have read each of the above statements and I understand it contents. I understand I have had an opportunity to ask questions regarding any of thcae policies before providing consent. Therefore, I hereby agree and consent to all these statements and policies of Speech Therapy Plus. _____ (please initial)

Patient Name _____

Patient Signature _____

Date _____

1421 FM 359 Richmond, TX 774OG 281-232-1900

- "I understand that, in the opinion of Speech Therapy Plus Pllc, the services or items that I have requested to be provided to me on _____ may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the HHSC or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care."

- "Comprendo que, segtn la opini6n del Speech Therapy Plus Pllc, es posible que Medicaid no cubra los servicios o las provisiones que solicite _____ por no considerarlos razonables ni medicamente necesarios para mi salud. Comprendo que el Departamento de Salud de Texas o su agente de seguros de salud determina la necesidad medica de los servicios o de las provisiones que el cliente solicite o reciba. Tambien comprendo que tengo la responsibilidad de pagar los servicios o provisiones que solicite y que reciba si despuds se determina que esos servicios y provisiones no son razonables ni medicamente necesarios para mi salud."

Patient Name _____ Date _____

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11/08/2021

Dear Parents/Patients,

Please be aware we are enforcing and updating our therapy “No Show Attendance” Policy. When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient. We understand that things happen. Therefore, it is important that you call the office within 4 hours in advance to cancel or reschedule your appointment. If for any reason, you need to cancel an appointment, please notify our office as soon as possible. Our therapists are paid “per visit” so they count on you keeping your appointments.

Effective immediately, any patient that does not show up for their scheduled appointment or cancels their appointment less than 4 hours in advance, will incur a $35 charge to their account. Payment of this charge will be required prior to your next scheduled appointment.

We ask that you please sign below and return to our office reflecting your acceptance of this policy. For Medicaid patients, please acknowledge that you waive the “no fee” restriction.

Thank you for choosing Speech Therapy Plus!

I have read the above and understood Speech Therapy Plus, PLLC’s “No Show Attendance” Policy.

Patient/Legal Guardian

Signature Date

Patient Name – Please print

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Credit Card Authorization Form

In order for us to process your credit card paynent(s), please complete this form.

Patient Name: _____

Card holder name, if different than patient; _____

Card holder address: _____

Card holder city, state, zip: _____

Card holder phone: _____

Credit card type (select one): ◯ Visa ◯ Mastercard

Credit card number: _____

Expiration date: _____

CVS Security Code (3 digit number on back of card) _____

Name as it appears on Credit Card _____

Statement of Authortzafion
Confidentlal Informatlon

To; Speech Therapy Plus,

I agree to pay for Speech Therapy Treatments for the above named patient on each date services are rendered. I agree to pay the amount determined by insurance or the $70.00 private pay amount per session.

Speech Therapy Plus is authorized to charge the cost of therapy services to my credit card as stated.

Cardholder Signature: _____ **Date:** _____