BABEL THERAPY, PLLC

## Patient Information and Financial Authorization

**Patient Name:**_____ **Date of Birth:**_____
(First) (Last) (Middle)

**Address:**_____
(Street) (City) (State) (Zip)

**Phone: Home:** _____

**Cell:**_____

**Work:**_____

**E-mail:**_____

**Patient Social Security #**_____-_____-_____

***required for commercial insurance, Medicaid and Medicare billing**

**Patient: Single ( ) Married ( ) Divorced ( ) Widowed ( ) Dependent ( )**

**Parent/Guardian Name:**_____

**Name of Insurance (PRIMARY):**_____

**Policy #** _____ **Group #:** _____

**Name of Insured:**_____ **Relationship to Patient:**_____

**Insured Party's Date of Birth:**_____ **Insurance Phone:** _____

**Employer:**_____ **Employer Phone:**_____

**Employer Address:**_____

**Name of Insurance (SECONDARY):**_____

**Policy #**_____ **Group #:** _____

**Name of Insured:**_____ **Relationship to Patient:**_____

**Insured Party's Date of Birth:**_____ **Insurance Phone:**_____

**Employer:**_____ **Employer Phone:**_____

**Employer Address:**_____

## *IN CASE OF AN EMERGENCY*

**Notify:**_____ **Phone:**_____
Cell ( ) Home ( ) Work ( )

**Relationship to Patient:**_____

**Name of Nearest Relative:**_____ **Phone:**_____
Cell ( ) Home ( ) Work ( )

**Address**_____
(Street) (City) (State) (Zip)

# Babel Therapy payment of benefits authorization

Payment is required in full at time of service.

I agree to be responsible for payment of services.

Signature Date

I authorize release of any medical information necessary to process my claims.

Signature Date

I authorize payment of medical benefits to Babel Therapy, pllc., for services provided.

Signature Date

Witness Signature Date

# CONSENT TO COMPLY WITH FEDERAL HIPAA ACT

## Patient Consent for Use and Disclosure of Protected Health Information

With my consent and signature, Babel Therapy, PLLC may use and disclose protected health information about me or my child to:

1. Carry out treatment, payment, and healthcare operations (services).
2. Call my home or other designated locations and leave a message on voice mail in reference to any items (i.e. appointment reminders, insurance items, references to clinical care of laboratory results, etc.) that will assist in the practice of medical care for me or my child.
3. Mail to my home or other designated address any item (i.e. appointment reminder cards, patient financial statements, etc.) that will assist in practice of medical care form me or my child. Such correspondence is to be marked personal and confidential.
4. Send or transmit email to any location provided by me for all above similar items and purposes.
5. To use and/or disclose protected health information about me or my child to/with third parties involved in mine or my child's care. Such parties may include, but are not limited to, insurance companies, hospitals, specialty physicians, and laboratory personnel. I may specifically describe the type of information (i.e. dates of services, level of detail, origin of information, etc.) subject to disclosure and may revoke this permission at a time and date chosen by me. By providing a written statement to the privacy office of Babel Therapy, PLLC, I may revoke this permission; however, Babel Therapy, PLLCmay decline to provide further treatment to me or my child. Babel Therapy, PLLC may also decline further treatment to me or my child should my restrictions on the type of third party information, in the center's opinion, impede medical care of me or my child.

I have the right to review the Notice of Privacy Practice Manual of Babel Therapy, PLLC. Babel Therapy, PLLC may revise its manual and procedures at any time deemed necessary, and I may request from time to time, in writing, a copy of such changes, should these changes directly relate to mine or my child's care.

I have the right to request that Babel Therapy, PLLC restrict how it uses or discloses mine or my child's health information. However, as state previously, Babel Therapy, PLLC is not required to agree to my restrictions. If Babel Therapy, PLLC accepts my restrictions, Babel Therapy, PLLC is then bound by the restriction in the agreement, setting forth the restricted information until providing me, in writing, a cessation of such agreement.

I may revoke this entire consent, in writing, at any time. If I do not sign this consent, or revoke this consent, Babel Therapy, PLLC, in their sole discretion, may decline further treatment for me or my child.

The Federal HIPPA (Privacy Act) of 2001 was created to protect mine and my child's health information. I understand this must be accomplished within the provisions and rules set up by Babel Therapy, PLLC to fulfill federal law. I may request to review the manual which spells out these provisions. Babel Therapy, PLLC will comply with this law to preserve privacy. If compliance with this law impedes the medical care of the patient, Babel Therapy, PLLC may decline to provide further care. Babel Therapy, PLLC will strive to provide information so that I may make an informed decision concerning the privacy of mine or my child's medical information.

_____
Signature of Parent or Legal Guardian of Minor Child

_____ _____ _____
Patient's Name Date of Birth Date of Signature

_____ _____
Printed Name of Signature Above Initials of Witness

Revised 6/2013

## CONSENT TO EXCHANGE INFORMATION

Patient's Name: _____ Date of Birth: _____

Current Address: _____

Telephone Number(s): _____

**I hereby give my consent for the Babel Therapy, PLLC to exchange information with:**

(Name and Address of Agency/Individual)

_____

_____

_____

**Information exchanged may include but is not limited to speech/language and hearing records, medical reports, academic information and program planning. Information may be shared through written reports, by phone, fax or in person.**

All of the information I hereby authorize to be exchanged with the above will be held strictly confidential and cannot be released without my written consent. I understand that I have the right to inspect and copy the information to be disclosed. I understand that I may withdraw this authorization at any time.

This request is effective up to and including six (6) months from the date of signature.

☐ By checking this box, you authorize Babel Therapy, PLLC to periodically send you, via email or U.S. mail, helpful information related to communication disorders, special promotions the Practice may have to offer, and/ or information about special fundraising events to benefit the Practice.

_____ _____

**Signature of Consenting Party** **Relationship to Patient (must be legal guardian/conservator)**

_____

**Date**

# BABEL THERAPY, PLLC

## CURRENT MEDICATION LIST

Patient Name:_____ ID number:_____

Allergies: ☐No Known Drug Allergies (NKDA) ☐Food Allergies: _____

☐Other:_____

| Date | Medication | Dosage/Frequency | Route of Administration |
|---|---|---|---|
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12302 Bluff Haven Ln
Cypress, TX 77433
PH: 936.703.5064
FX: 1-844-559-5504
www.BabelTherapy.com

**CASE HISTORY - CONFIDENTIAL INFORMATION**

Patient Name: _____

Today's Date: _____

Person completing this form: _____

Relationship to patient: _____

Who referred you to Babel Therapy? _____

Reason for Visit: _____

Medical Diagnosis: _____

Physician Name: _____ -- Phone Number: _____

Address: _____

Past surgeries: _____

Past hospitalizations: _____

Medical Conditions: _____

_____

Describe any physical disability or condition:

_____

_____

Vision Status:

Wears glasses ☐YES ☐NO

Legally Blind ☐YES ☐NO

Hearing Status:

Hearing impairment ☐YES ☐NO

If yes, describe:

_____

Wears hearing aids ☐YES ☐NO

**Please answer the following questions, when applicable:**

Please describe your present speech problem.

What do you think caused your speech problem?

Has the problem become worse or has it seemed to improve? Please explain.

What conditions seem to make the problem better or worse?

How does speech affect your job or other aspects of your life that require communication? Please explain. (For example, do you withdraw from communicative situations because of your problem, or has it affected your choice of a job?)

Do other members of your family have a similar problem or other speech problem? Please explain.

What strategies have you used at home to work on this problem?

Have you received any help for this problem (speech pathologists, doctors, or other professionals)? Please explain:

Have you had any serious accidents? If so, please explain.

Have you had any chronic illnesses? If so, please explain.

Please indicate any surgeries or illnesses related to this speech problem.

Babel Therapy
Changing Lives Through Communication

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Phone: 936.703.5064 Fax: 844.559.5504
www.babeltherapy.com

# Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

| **Credit Card Information** |
|---|
| Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX<br>☐ Other _____ |
| Cardholder Name (as shown on card): _____ |
| Card Number: _____ |
| Expiration Date (mm/yy): _____ |
| Cardholder ZIP Code (from credit card billing address): _____ |

I,_____, authorize_____to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____
Customer Signature Date