



Elite Concierge Speech and Language Services LLC

Please complete as much of this evaluation packet as possible prior to your first appointment. If you need help with any sections, you may call (239) 544-2287 or email information@eliteconciergespeech.com and a representative will be happy to assist you.

Adult Intake Form

Full name: _____ Date of birth: _____

Address: _____

City: _____ Zip Code: _____

Home phone: _____

Cell phone: _____

Work phone: _____

Email address: _____

Occupation (current or previous): _____

Highest Level of Education: _____

Language(s) spoken: _____

Hobbies: _____

Primary Doctor's Name: _____ Phone : _____

Reason for requesting services (please include as many details as possible):

Other doctors (name, specialty, phone):

Allergies: _____

Current medications (name, dose):

Other medical conditions:

Recent or major surgeries and hospitalizations (please include dates).

Please answer yes or no:

Client would like to improve speech _____

Client would like to improve understanding or expressing language _____

Client would like to improve cognition (i.e. attention, problem solving, judgement, working memory) _____

Client would like to improve swallow safety _____

Person completing form: _____

Relationship to client: _____

Signed: _____

Date: _____



MEDICAL RECORDS RELEASE FORM AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

1. I, _____, of _____,
 (Client or Representative) (Self or Client Name)

date of birth: _____ hereby authorize Elite Concierge Speech and Language Services LLC to use, disclose and/or discuss the following protected health information listed below from my medical records. I understand the information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting confidentiality.

2. Persons or entities with whom Elite Concierge Speech and Language Services LLC may disclose/discuss your Protected Health Information: (Releases: i.e. family member, doctor, dentist, therapist)

Name/Title	Address	Phone/Email

3. Elite Concierge Speech and Language Services LLC is authorized to disclose/discuss the following information, including but not limited to: medical records; treatment records (progress notes, daily session notes); speech, language, academic, and/or swallowing test results; and evaluations/therapy progress as it relates to therapy/treatment and evaluations at Elite Concierge Speech and Language Services LLC.

4. This information is being used or shared for medical, insurance, legal, and/or educational purposes.

5. I understand that I may revoke this authorization at any time by requesting such of Elite Concierge Speech and Language Services LLC in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

 Patient/Guarantor Signature

 Date

 Patient/Guarantor Name (Printed)

 Relationship to Patient (Printed)

THERAPY POLICIES

Elite Concierge Speech and Language Services LLC provides a model of care that allows our clients to maximize their potential for progress. Our therapy policies allow us to serve each client individually during the day, evening, and weekend hours with a therapy plan they design.

Cancelled Appointments

24 hours' notice is required for any cancelled appointment. Failure to provide 24 hours' notice will result in a \$50.00 cancellation fee charged to your account. Exceptions will be made for occasional and unavoidable circumstances, such as sudden illnesses, that do not allow for advance notice.

No-Show

Our therapists spend time planning and preparing for each therapy session. Missed appointments without prior notice (either directly to the treating therapist or administrative staff) will be charged at the private pay rate.

I acknowledge receipt of and agree to the therapy policies of Elite Concierge Speech and Language Services LLC.

Signature: _____

HIPAA PRIVACY NOTICE ACKNOWLEDGMENT

1. Elite Concierge Speech and Language Services LLC is required by law to keep your health information safe. This information may include notes from your doctor, teacher, or other health care providers; your medical history; your test results; treatment notes; and insurance information.
2. Elite Concierge Speech and Language Services LLC is required by law to give you a copy of our privacy notice. This notice explains how your health information is used and/or shared. It also explains you how you can obtain your information and comment on it.

I acknowledge receipt of Elite Concierge Speech and Language LLC's Privacy Notice.

Signature: _____

AT WILL SERVICES ACKNOWLEDGMENT

Elite Concierge Speech and Language Services LLC is a concierge, private-pay agency that does not participate with federal or private insurance. Elite Concierge Speech and Language Services LLC provides optional wellness services without requiring a physician referral, and do not need to meet criteria for medical necessity. Concierge services may be stand-alone or a supplement to a medical plan of care, but are not intended to replace a medical plan of care. All services are strictly optional, allowing us to personalize your treatment plan and frequency/duration of services to the degree of your choosing.

I acknowledge receipt of Elite Concierge Speech and Language At Will Services Acknowledgement.

Signature: _____

PAYMENT AGREEMENT

Payment is private-pay and due at time of services rendered. Any costs incurred by Elite Concierge Speech and Language Services LLC for any returned checks or insufficient funds is the client/guarantor's responsibility.

I acknowledge receipt of and agree to the Payment Agreement outlined above.

Signature: _____

In consideration for the professional services rendered by Elite Concierge Speech and Language Services LLC, I acknowledge receipt of and agree with the Office Policies and Agreements outlined above.

Client/Guarantor Signature

Date

Client/Guarantor Name (Printed)

Client/Guarantor Name (Printed)