GROWING SPEECH, PLLC

5757 Flewellen Oaks Lane, Suite 604, Fulshear, Texas 77441
jodie@growingspeech.com - 281-969-3692

Adult Intake Form / History

Today's Date _____
Client Name: _____ Nickname: _____
Date of Birth: _____ Age: _____ ☐ Male ☐ Female
Diagnosis (if known): _____
Address: _____
City, State, Zip: _____
Phone #1:_____ ☐ Cell ☐ Home ☐ Work ☐ Other
Phone #2:_____ ☐ Cell ☐ Home ☐ Work ☐ Other
Email #1:_____ Email #2: _____
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced
If under 18, name of parent/guardian: _____
Name of Spouse or Closest Relative: _____
Permission to Contact: ☐ Yes ☐ No
Contact Information: _____
Others Living In the Home: _____
_____
Are you receiving any assistance in the home? ☐ Yes ☐ No
Describe:_____
Language(s) Spoken: _____
Are you currently driving? ☐Yes ☐No

Client's Physician: _____
Physician Phone Number: _____
Physician Address: _____

Other Physicians / Specialists Involved In Care:
Referring Physician: _____ Phone Number _____
Physician Address: _____
Secondary Physician: _____ Phone Number _____
Physician Address:_____

Occupation: _____☐ Employed ☐ Retired ☐ Unemployed

How did you hear about us?
_____

Current Status

Please describe your present issue: _____
_____
_____
_____

Is your communication difficulty related to your work? ☐Yes ☐No
Is your communication difficulty related to an accident? ☐Yes ☐No
Date of occurrence: _____
Describe: _____
_____
_____

Briefly describe why you're seeking an evaluation by a speech-language pathologist at this time: _____
_____
_____
_____

What do you think caused your speech problem? _____
_____
_____
_____

What are you expecting out of this evaluation / meeting? _____
_____
_____

Have you ever had a previous speech, language or feeding evaluation / treatment?
☐Yes ☐No By whom: _____When: _____
Describe the results: _____
_____
_____

Are you currently working with another provider? ☐Yes ☐No
Provider Name: _____
Contact Information: _____
Location: _____

Has the problem improved or gotten worse? Describe: _____
_____
_____
_____
When did you first notice the problem? _____
_____
_____
_____

How does your communication difficulties impact your life, social, work, hobbies, etc.?
_____
_____
_____
_____

What strategies do you use to help cope with this problem? _____
_____
_____
_____
_____

Does anyone in your family have a history of the same (or different) communication difficulty? _____
_____
_____
_____
_____

Background & History

Describe any pertinent information your medical history (birth injuries, abnormalities, surgeries, diagnoses, etc.) as well as when they were diagnosed and by whom:
_____
_____
_____
_____
_____
_____
_____
_____
_____

Describe your current health status: _____
_____
_____

Have you ever had surgery for a related issue? ☐ Yes ☐ No
Please describe: _____
_____
_____

Have you ever been hospitalized for a related issue? ☐ Yes ☐ No
Please describe: _____
_____
_____

Have you ever been in a serious accident? ☐ Yes ☐ No
Please describe: _____
_____
_____

Do you have a chronic illness? If so, please describe: _____
_____
_____

Are you currently on any medications? If so, please list medication name and reason for medication:
Medication 1: _____
Medication 2: _____
Medication 3: _____
Medication 4: _____

Do you have any physical disabilities? _____
_____
_____
_____

Do you currently use any equipment? (communication device, walker, etc.) Describe:
_____
_____
_____

Check and describe all that apply:

☐Allergies Describe: _____
☐Asthma Describe: _____
☐Attention Deficit Disorder Describe: _____
☐Auto accident Describe: _____
☐Brain injury Describe: _____
☐Breathing problems Describe: _____

☐Cancer Describe: _____
☐Cardiac issues Describe: _____
☐Cleft palate Describe: _____
☐Cognitive issues Describe: _____
☐Degenerative illness Describe: _____
☐Depression Describe: _____
☐Developmental delay Describe: _____
☐Diabetes Describe: _____
☐Ear infections Describe: _____
☐Encephalitis Describe: _____
☐G-tube Describe: _____
☐Hearing loss Describe: _____
☐Pneumonia Describe: _____
☐Psychiatric issues Describe: _____
☐Respiratory problems Describe: _____
☐Seizures Describe: _____
☐Stroke / TIA Describe: _____
☐Swallowing problems Describe: _____
☐Other Describe: _____

Have you ever been evaluated by the following specialties? Check all that apply
☐Audiologist ☐Gastroenterologist ☐Occupational Therapist
☐Otolaryngologist ☐Physical Therapist ☐Psychologist
☐Psychiatrist ☐Speech Therapist
If yes, please describe the nature of the evaluation and any results: _____
_____
_____

Highest grade completed: _____ Degree earned: _____
Name of Institution(s): _____

During school, did you have any problems with the following? Check all that apply:
☐Learning ☐Understanding ☐Memory ☐Behavior ☐Attention
☐Reading ☐Speaking ☐Writing ☐Problem Solving
Describe: _____
_____
_____

What are your responsibilities in the home? Check all that apply:
☐Cooking ☐Cleaning ☐Child care ☐Driving ☐Finances

☐Laundry ☐Repairs ☐Shopping ☐Yard work

Are there any questions you would like us to answer for you? _____
_____
_____
_____

Is there anything else that is important for us to know about you?
_____
_____
_____
_____
_____
_____

Person filling out the form: _____
Relationship to the client: _____

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PRIVACY NOTICE

Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information.

PLEASE REVIEW CAREFULLY

Who will follow this notice:

1. Any health care worker authorized to enter information into your chart including practicing physicians and other credentialing individuals who are part of the Organized Health Care arrangement that participates in providing care and assisting Growing Speech, PLLC operational activities.
2. Business associated affiliated with Growing Speech, PLLC
3. All employees and staff members of Growing Speech, PLLC

Our pledge regarding your information: Understand that information about you and your health are personnel and considered Protective Health Information (PHI). We are committed to protecting information about you. We are required by law to create and maintain a record of the care provided by Growing Speech, PLLC. How we may use and disclose information: This notice describes different ways we use and disclose PHI. Not every use or release will be listed. However, all of the ways that we are allowed to use and disclose information will be stated. We may use PHI (including information from previous treatment) to provide medical treatment or services. We may disclose information to your doctors, students, technicians, therapists, and therapy assistants or other Growing Speech, PLLC employees who may be involved in your care. We may also disclose to people outside of Growing Speech, PLLC who may be involved in your medical care after you leave such as any members or others we use to provide services. We may use and disclose PHI about you to create bills and payments. We may contact insurance companies to inquire or verify coverage. We may contact you to remind you of your appointments for clinical follow ups and for customer service. We may release PHI to a family member who pays for your care. We have to disclose PHI when required by federal, state, or local laws. We are required to disclose PHI to health authorities to prevent a serious threat to your health and/or safety of the public or another person. We may release information to the military and workmen's compensation. PHI may be released for public health issues. We may release information the coroner, medical personnel or for national security and intelligence.

Your rights regarding information about you: We have the right to review and copy information about you. We require a written request to inspect and copy PHI. If any information about you is incorrect or incomplete you can request an amendment as long as the information is kept by or for Growing Speech, PLLC. You also have a right to receive an accounting of disclosure. You can request in writing a notification on where we disclose PHI. You can request that we contact you at a specific location or in a certain manner. You have a right to a paper copy of this notice. We reserve the right to make changes to this notice and continue to maintain confidentiality of all healthcare information. We disclose the effective date on this notice. Uses and disclosures of PHI will be made only with your written permission.

If you have any questions or you want to file a complaint, please contact Growing Speech or contact the Texas Department of Health and Human Services (toll free) at 1-800-735-2989. You will not be penalized for complaint.

Signature of Patient/Parent/Legal Guardian	Date	Signature of Witness	Date

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Acknowledgement That You Have Received Our HIPAA Privacy Notice

Growing Speech, PLLC is required by law to keep your health information and records safe.
This information may include:

- Notes from your doctor, teacher or other healthcare provider
- Medical history
- Test results
- Treatment notes
- Insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information may be used and shared.

☐ **I acknowledge that I have received a copy of Growing Speech, PLLC's HIPAA Notice of Privacy Practices that fully explains the uses and disclosures they will make with respect to my individually identifiable health information.**

☐ **I have had the opportunity to read the notice and to have any questions regarding the notice answered to my satisfaction.**

☐ **I understand *Growing Speech, PLLC* cannot disclose my health information other than as specified in the notice.**

☐ **I understand that *Growing Speech, PLLC* reserves the right to change the notice and the practices detailed therein if it sends a copy of the revised notice to the address I have provided.**

_____ _____
Print Name of Patient Date

_____ _____
Signature of Patient or Legal Representative Relationship to Patient

Please Note: It is your right to refuse to sign this Acknowledgement.
HIPAA Privacy Notice Acknowledgement

_____
Office Use Only

I tried to obtain written Acknowledgement of our Privacy Notice by the patient/legal representative noted above. It could not be obtained for the following reason(s)

- An emergency prevented us from obtaining acknowledgement.
- The individual was unwilling to sign.
- A communication barrier prevented us from obtaining acknowledgement.
- Other: _____

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Attendance / Cancellation Policy

Attendance and participation in therapy along with complete compliance with any associated home programs are essential for therapeutic success.

While *Growing Speech, PLLC* understands that illnesses and emergencies occur, we respectfully request that you avoid frequent cancellations or "no shows". Please adhere to our following policy regarding providing our office with advance notification for any cancellations resulting from a conflicting appointment, vacation, or any other event.

All cancellations must be submitted 24 hours prior to your scheduled appointment.

☐ A fee of $20 may be assessed if the following occurs. This fee will be billed directly to the client and not to their health insurance company, as medical insurance does not provide coverage for missed sessions.

- If cancellations are made less than the required 24 hours.
- If the client fails to show up for a scheduled appointment.

☐ If you miss / reschedule / are late for 3 scheduled appointments, the office reserves the right to discharge the client. Additionally, if you arrive late for a scheduled appointment, the session will still end at the scheduled time or may be cancelled.

☐ I, _____, understand the attendance / cancellation policy and the risks of not adhering to it.

_____ _____
Print Name of Client Date

_____ _____
Signature of Participant or Legal Representative Relationship to Client

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Payment Policy

Thank you for choosing our private practice to serve you. We are committed to providing you with the highest quality care. Please know that the timely payment of your bill is an integral part of our service and as such, this payment policy is an agreement between you and *Growing Speech, PLLC* for payment of services provided. By signing this policy, you are agreeing to pay for services provided to you or your family member. As a client of *Growing Speech, PLLC,* you are required to carefully review and sign our payment policy.

Please read the following information carefully:

All therapy fees (including session fees and/or co-pays, if applicable) are due at the time of service.

We accept the following payment methods at this time: credit card or check (Checks should be made payable to *Growing Speech, PLLC).*

We will provide you with an invoice outlining the services rendered and the amount charged.

Please read and check all boxes to acknowledge understanding and sign below:

☐ I understand that I am responsible for all costs / fees that any third-party payer (ex. insurance company, private school, etc.) does not cover. In the event that a third-party payer source determines that rendered therapy services are "not covered" or otherwise denied, I will be responsible for all outstanding charges. I understand that I will be billed accordingly and will be responsible for immediate payment. I also understand that *Growing Speech, PLLC* will not become involved in disputes between you and your third-party source regarding uncovered charges or reasons for denial.

☐ I understand that if fees are not paid in full, treatment sessions may be postponed or cancelled until payment is received.

☐ I understand that all returned checks will be subject to a $30 returned check fee. Charges incurred and not paid after 14 days may be turned over to a collection agency at the client's expense. Overdue accounts may also be reported to a Credit Bureau.

☐ I understand that I am responsible for all legal and collection fees, which *Growing Speech, PLLC* may incur if payment is not made in accordance with the terms and conditions herein.

☐ I understand that refunds will be issued only in instances of overpayment. All refunds will be processed within 2 weeks after the overpayment is discovered on the client's bill or at the time the refund is requested. Refunds for payments made with a credit card will be credited back to the credit card used, all other refunds will be issued by a check. Clients who used a third-party source will not be issued a refund until full payment is received from the appropriate source.

☐ I, understand that all cancellations require 24 hours notice and that there will be a $20 charge for any cancellations made less than 24 hours. This charge is my sole responsibility and will not be covered by a third-party source.

☐ I, _____, (client / guardian name) understand the payment policy and the risks of not adhering to it.

_____ _____
Print Name of Client Date

_____ _____
Signature of Client, Guardian or Responsible Party Relationship to Client

_____ _____
Private Practitioner / Witness Date

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Equipment Use Waiver

It is our goal to promote a fun and safe environment for our children during therapy. However, there are inherent risks associated with the use of our therapeutic space (e.g. furniture, toys, therapeutic ball, etc.). While we provide therapy in the safest manner possible, the risk of injury from use of our therapeutic space is possible.

By signing below, I understand:

- Therapeutic materials are provided to reinforce and improve my child's communication
- Rules for use are explained to my child and supervision while in use is provided at all times.
- I assume all risks and hazards incidental to participation with use of therapeutic tools, I do hereby waive, absolve, indemnify and agree to hold harmless Growing Speech, PLLC and any partners, employees, managers, and affiliates- except to the extent and in the amount covered by liability insurance.
- I understand medical insurance is NOT provided by Growing Speech, PLLC should injury occur.
- I understand that should significant injury occur as a result of use, 911 will be the initial call followed in order by the persons listed on this form below.

Please read carefully and sign to indicate your agreement. Note: This form includes a release of liability.

For and in consideration of my child being permitted to participate in therapeutic and reinforcement activities, I hereby voluntarily release, discharge, waive and relinquish any and all claims or actions for damages for personal injury, permanent disability, death, or property damage which I or my child may have, or which may hereafter accrue to me or my child, as a result of my participation in therapy during play, and while I am at the facility while others play, or for any other reason. This release is intended to discharge, in advance, Growing Speech, PLLC, it's officers, employees and agents, and the owners and maintainers of any facility used for therapeutic activities, from any and all liability arising out of or connected in any way with my child's participation in therapy, camps, clinic activities, even though that liability may arise out of negligence or carelessness on the part of Growing Speech, PLLC its officers, agents or

employees, or the owners or maintainers of any facility used by *Growing Speech, PLLC* for therapeutic activities.

I further understand that serious accidents occasionally occur during therapeutic activities, and that participants occasionally sustain serious personal injuries, death or property damage as a consequence thereof. Knowing the risks, I have voluntarily applied for my child to participate in the activity and thereby agree to assume those risks to release and hold harmless Growing Speech, PLLC, its officers, employees or agents, or the owners or maintainers of any facility used by Growing Speech, PLLC for therapy and reinforcement activities, who (through negligence or carelessness) might otherwise be liable to me or to my child (or my heirs or assigns) for damages.

I further understand and agree that this release, discharge, waiver, and assumption of risk is to be binding on my and my child's heirs, executors, administrators, and assigns. I further agree to indemnify and to hold harmless Growing Speech, PLLC, its officers, employees and agents, or the owners or maintainers of any facility used by Growing Speech, PLLC for treatment, fundraising, or therapeutic activities, for any loss, liability damage, cost or expense which may incur as a result of any injury or property damage I or my child may sustain while participating in the activity.

I agree to comply with the program's stated and customary terms and conditions for participation according to Growing Speech, PLLC. If I observe any significant change with regards to my child's readiness for participation in the program, I will remove my consent immediately.

I have read this Informed Consent/General Release, fully understanding its terms, that I give up substantial rights by signing it, and sign it voluntarily. By my signature below, I certify that I have read, fully understand and accept all terms of the foregoing statement.

_____ _____

Signature of patient/parent/legal guardian Date

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Consent for Services

☐ I authorize *Growing Speech, PLLC* to render appropriate evaluation and therapy services to the client named below in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained health professional. I recognize, agree and understand that I have the right to refuse treatment or terminate services at any time by *Growing Speech, PLLC* in writing. In addition, *Growing Speech, PLLC* may terminate services by notifying me in writing.

☐ I do not give my consent or am withdrawing my consent regarding *Growing Speech, PLLC* rendering evaluation and therapy services to the client named below.

_____ _____
Print Name of Client Date

_____
Client Date of Birth

_____ _____
Signature of Client or Legal Representative Relationship to Client

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General Acknowledgement of Forms

☐ I hereby acknowledge and agree that I read all of the forms and documents provided to me in connection with the evaluation and treatment provided by *Growing Speech, PLLC* and/or their employees.

☐ I fully understand the meaning and intent of the forms provided and I agree to all content included.

☐ I have been given an opportunity to ask questions about the forms provided. All my questions have been answered to my satisfaction by *Growing Speech, PLLC*.

_____ _____
Print Name of Patient Date

_____ _____
Signature of Participant or Legal Representative Relationship to Patient