GREAT BASIN SPEECH THERAPY

COMPREHENSIVE IN-HOME SPEECH & LANGUAGE THERAPY

INTAKE PAPERWORK

CHILD'S INFORMATION

NAME: _____DATE OF BIRTH _____/_____/_____ MALE OR FEMALE

ADDRESS: _____CITY: _____

STATE: _____ ZIP_____ HOME PHONE (_____) _____

CELL PHONE: (_____) _____ E-MAIL: _____

MAILING ADDRESS, (IF DIFFERENT): _____

_____

REFERRED BY: _____ BEST WAY TO CONTACT ME: _____
(Call/Text/Email, Etc.)

PRIMARY CARE MD: _____

MD CONTACT INFORMATION & NAME OF PRACTICE:_____

PARENT / GUARDIAN / POWER OF ATTORNEY

NAME: _____DOB:_____

RELATIONSHIP TO CLIENT: _____ EMAIL ADDRESS: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ HOME PHONE: (_____) _____

CELL PHONE: (_____) _____ WORK PHONE: (_____) _____

EMPLOYER: _____

EMERGENCY CONTACT

NAME: _____

PHONE: (____) _____ RELATIONSHIP TO CLIENT: _____

INSURANCE

PRIMARY INSURANCE _____

POLICYHOLDER NAME: _____

DOB: _____/_____/_____ RELATIONSHIP TO CLIENT: _____

GROUP # _____ ID # _____

SECONDARY INSURANCE _____

POLICYHOLDER NAME: _____

DOB: _____/_____/_____ RELATIONSHIP TO CLIENT: _____

GROUP # _____ ID # _____

GREAT BASIN SPEECH THERAPY CLIENT INFORMATION

Can confidential messages (i.e., appointment reminders) be left on your telephone, voicemail, text, or email?
[ ] Yes [ ] No If no, please specify how you prefer to receive information _____

Please list the family members or other persons, if any, whom we may inform about your child's general medical condition and diagnosis. (Including treatment, payment, appointments, and healthcare operations)

_____

Do you have a durable power of attorney for healthcare providers? Yes [ ] No [ ] Please Initial _____

Are you currently receiving therapy services anywhere else? Yes [ ] No [ ]

If yes, where and what type? _____

AUTHORIZATION AND RELEASE OF INFORMATION (Please Initial Each)

_____ I authorize Great Basin Speech Therapy to release any information including the diagnosis and the records of any treatment or examination rendered during the period of such care to third-party payers to facilitate payment of a claim, or the other health practitioners for continuity of care. This includes verbal, written, and faxed releases.

_____ I have been offered a copy of Great Basin Speech Therapy's Notice of Privacy Practices (HIPAA). I understand that Great Basin Speech Therapy has the right to alter its Notice of Privacy Practices from time to time, and I may contact them at any time to obtain the latest version in person or by visiting Great Basin Speech Therapy's website.

Sign Here _____ Date: _____/_____/_____

AGREEMENT/AUTHORIZATION FOR SERVICES (Please Initial & Sign <u>Both</u> Places)

_____ It is necessary to comply with your treatment program prescribed by your physician and provided by your therapist consistently. Cancellations should be made at least twenty-four (24) hours in advance of the appointment.

_____Cancellation of appointments without 24-hour notice and/or NO SHOW of an appointment may be subjected to termination of your repeat or future appointments.

CLIENT'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize the release of any medical or other information necessary to process claims.

Sign Here _____ Date: _____/_____/_____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize payment of medical benefits to Great Basin Speech Therapy for services rendered.

Sign Here _____ Date: _____/_____/_____

MEDICARE CLIENTS ONLY

Are you currently receiving Home Health Services? Yes [ ] No [ ]

(Please note that if you are receiving Home Health Services and your services from Great Basin Speech Therapy are denied, you will be responsible for the balance due.) (Please Initial) _____

CLIENT RIGHTS AND RESPONSIBILITIES (Please Read and Sign)

I am aware that I may be treated in an open area and not in a private treatment room.

A Client has the right to confidentiality whether medical, financial, and/or personal.

A Client has the right to understand all treatment and treatment options.

A Client has the right to receive the information contained in medical records.

A Client has the responsibility to provide total and accurate billing information.

A Client has the responsibility to comply with medical advice and if non-compliant with medical advice, the Client agrees to advise their physician.

A Client has the responsibility to understand and abide by Great Basin Speech Therapy policies.

A Client has the responsibility to ask questions if they do not understand any of their rights and responsibilities.

_____ _____

Client Name Date

_____

Client Signature (Parent or Guardian if the child is a minor)

FINANCIAL POLICY AND GUIDELINES (Please Read & Initial Each)

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

_____ Payment **is expected at the time of service** unless prior arrangements have been made. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty (30) days of billing date. **The obligation for the full payment of this account remains your own and if the insurance company fails to make payment within sixty (60) days, you will be expected to pay the total balance of this account.**

_____ I understand that if my account is turned over to a collection agency, I will be responsible for all charges encountered in the collections process.

_____ In some instances, we may accept assignment of insurance benefits, however, you are ultimately responsible for the bill. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services that they will not cover.

_____ All charges are your responsibility.

_____ Fees for these services, along with unpaid deductibles and copayments are due at the time of treatment or on a monthly basis depending on your arrangement.

_____ It is your responsibility to understand copayments, deductibles, and co-insurance and to be aware and inform Great Basin Speech Therapy of any changes in your policy.

_____ Unless an appointment is canceled at least twenty-four (24) hours in advance, you may be charged with a cancellation fee of $50. (We honor a one-time no-show, without charge, afterward you will be responsible for the no-show charge. Please call if you must reschedule.

_____ A Client has the right to understand all billing and fees.

_____ A Client has the responsibility to provide current, total, and accurate medical history information.

Signature of Parent/Guardian/Client_____ Date_____

Client Name _____ Date _____