Pediatric and Adult Speech / Swallowing and Feeding Disorders & Pediatric Occupational Therapy
316B Kinderkamack Rd. Westwood, NJ 07675
208 Harristown Rd, LL2. Glen Rock, NJ 07452
tel: 201-297-9167 / fax: 201-829-0817
www.gardenstatespeech.com

ADULT BACKGROUND HISTORY QUESTIONNAIRE

Intake Date:_____

Full name of client: _____ DOB: _____ Age: _____
Gender: male/female/other
Address: _____
City: _____ State: ____ County: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____
Preferred contact (name/number): _____
Email: _____

Please list all immediate family members: Spouse/Partner: _____
Children & Age: _____
Siblings & Age: _____
Other pertinent Family: _____

Person providing intake: _____
Who referred client: _____ Phone:_____
Primary care provider: _____ Phone: _____
Would you like GSST to share the results of the evaluation with your primary care provider/referring physician: YES NO

Highest Level of Education: _____
Occupation(s), # of years, when retired: _____
_____

History
Medical History (please check all that apply)
___ Heart attack ___ Cardiac ___ Hypertension

___Diabetes
___ Stroke
___ Chronic laryngitis
___ Acid Reflux
___ Ear Infections
___ Meningitis
___ Seizures
___ Head Injury
___ Neurological Conditions
___ Allergies
___ Cancer: _____
___ Head/neck cancer
___ Shingles
___ Bronchitis
___ COPD
___ Sinusitis
___ Tuberculosis
___ Pneumonia
___ Asthma
___ Thyroid issues
___ Arthritis
___ Hearing loss
___ Cerebral Palsy
___ Intellectual deficits
___ Cleft Palate
___ chronic colds
___ facial nerve palsy
___ emotional/psychological
___ Multiple sclerosis
___ Huntington's Disease
___ Parkinson's Disease
___ Voice issues/changes
___ vocal polyps/nodules
___ TMJ
___ Sleep issues/disturbances: _____
___ Gastrointestinal (stomach) problems
___ Other: _____

Past Medical History: Present medical diagnoses including psychiatric diagnoses (if applicable):
_____
_____
_____

Hospitalizations/Surgeries: Please describe any hospitalizations/surgeries (if applicable):
_____
_____
_____

Medications: Please list any medications you are currently taking (if applicable):
_____
_____
_____

Allergies: Please list any allergies (if applicable):
_____
_____
_____

Speech-Language History (please check all that apply)
___ Difficulty swallowing
___ Difficulty expressing thoughts
___ Difficulty being understood by others
___ Difficulty understanding what others are saying to you
___ Difficulty with Orientation/memory
___ Difficulty with problem solving
___ Changes in Focusing/attention
___ Changes Reading/writing
___ Difficulty with word finding
___ Difficulty maintaining topic of conversation
___ Stuttering/fluency
___Difficulty following directions

___ Oral motor weakness/changes ___Changes in voice

Please describe your speech, language, cognitive, and/or swallowing concerns:

_____
_____
_____

When/how did you/spouse start noticing difficulty, please describe:

_____
_____
_____

Would you consider the problem: Mild? Moderate? Severe?

Have you been evaluated and/or treated by any of the following professionals?

___ Speech Language Pathologist
___ Occupational Therapist
___ Physical Therapist
___ Chiropractor
___ ENT
___ Allergist
___ Gastroenterologist
___ Neurologist
___ Specialist:_____
___ Other:_____

Please list any findings from seen healthcare professionals (if applicable):

_____
_____
_____

Recommendations healthcare professionals:

_____
_____
_____

Do you notice more difficulty in certain situations? Certain times of day? Fluctuating?

_____
_____
_____

How does the difficulty limit social/vocational activities?

_____
_____

_____

What do you hope to gain/improve from speech/language/cognitive therapy?

_____

_____

_____

Functional Activities Questionnaire

Ask informant to rate patient's ability using the following scoring system:

0	1	2	3
Normal *or* Never did it before, but could/can do it (e.g. spouse usually does it)	Does by self But has difficulty *or* Never did it, but would have difficulty	Requires assistance	Dependent/ Someone else does it

Activity	**Rating**
1. Writing checks, paying bills, balancing checkbook	**0 1 2 3**
2. Assembling tax records, business affairs, or papers	**0 1 2 3**
3. Shopping alone for clothes, household necessities, or groceries	**0 1 2 3**
4. Playing a game of skill, working on a hobby	**0 1 2 3**
5. Heating water, making a cup of coffee, turning off stove after use	**0 1 2 3**

6. Preparing a balanced meal	**0 1 2 3**
7. Keeping track of current events	**0 1 2 3**
8. Paying attention to, understanding, discussing TV, book, magazine	**0 1 2 3**
9. Remembering appointments, family occasions, holidays, medications	**0 1 2 3**
10. Traveling out of neighborhood, driving, arranging to take buses	**0 1 2 3**

TOTAL SCORE: _____

Pfeffer, R.I., Kurosaki, T.T., Harrah, C.H. Jr., Chance, J.M., & Filos, S. (1982). Measurement of functional activities in older adults in the community. Journal of Gerontology, 37(3), 323-329. Reprinted with permission of Oxford University Press.

garden state SPEECH THERAPY

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Financial Agreement

_____ I hereby give Garden State Speech Therapy, LLC authorization to file claims for services rendered on my behalf. Any claims that are not paid or authorized by the insurance carrier will be my responsibility.

_____ I authorize the release of any medical or other information necessary to process all claims.

_____ I understand that if payment is not issued by the insurance company within 45 days of the initial filing, I am responsible for following up with my insurance carrier and may be responsible for any payments not paid by my insurance carrier to Garden State Speech Therapy, LLC.

_____ Invoices are due within 15 days of receipt. A 20% late fee will be added to all late bills.

_____ If patient responsibility payment is not received within 30 days, therapy services might be put on hold. All balances more than 30 days old will be charged to the credit card on file.

_____ I understand that if patient responsibility payment is not made within 60 days, my/my child's appointment time will be forfeited until the balance due is paid in full and therapy services might be terminated. I understand that delinquent accounts may be referred to collections, incur interest collection and attorney's fees for which I will be responsible. Garden State Speech Therapy, LLC does not guarantee the same time slot once the payment has been made.

_____ I understand that a valid credit card on file is required for all scheduled appointments.

_____ GSST will re-submit denied insurance claims twice (2 times). All denied claims thereafter will be billed to the client at billed rate. GSST will make every effort to assist with insurance appeals upon request.

_____ All returned checks will incur a $30 service fee.

_____ I understand that it is my responsibility to inform the office of any insurance changes. Any charges incurred after the termination date of insurance policy are my responsibility

_____ All patient responsibility payments are due at the time of service

Date: _____ X_____

Print Name: _____

Parent/Guardian for: _____

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Attendance and Cancelation Policy

Consistent attendance of therapy sessions is paramount for progress. We offer consistent scheduling to all clients, with time slots reserved for each client. Our therapists make a commitment to their clients' progress, we ask that our clients make the same commitment by maintaining their attendance. We will make every effort to schedule make ups for all missed sessions. Make up sessions are offered based upon availability of therapists.

_____ We require 24 hour notice for cancellations. All cancelations of office visits **less than 24 hours in advance** and **no-shows** will incur a **$50 charge**. For traveling appointments, the full rate will be charged. **The $50 cancelation fee will be waived if the appointment is rescheduled and attended within 2 weeks. The $50 no-show fee will not be waived and no-show appointments will not be rescheduled**

_____ **Two (2) canceled and not rescheduled sessions in any 10-week period will result in appointment time loss at the discretion of GSST management. Attendance rate of 80% is expected**

_____ **2 consecutive no-shows will result in appointment time loss**

_____ I understand that cancelation and no-show fees cannot be billed to my insurance and are my responsibility.

_____ Sick children will be sent home. We will do our best to reschedule the appointment.

I have read and understood the attendance and cancelation policy. I hereby accept the attendance and cancelation policy in full.

Date: _____ X_____

Print Name: _____

Parent/Guardian for: _____

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Consent and Acknowledgement

Name of client:_____

Consent for care and treatment: As (self/parent/legal guardian), I hereby consent to necessary evaluation, procedures, and/or treatments prescribed by the speech therapist as is necessary in their judgment. I understand that I/my child is under the care of a speech language pathologist. I authorize the release of medical information to Garden State Speech Therapy, LLC for continuity of care.

HIPAA Notice of Privacy Practices: Garden State Speech Therapy, LLC will use and disclose personal health information for treatment, payment, and other healthcare operations and as otherwise permitted by law.

_____ _____

Signature Date

_____

Print Name

_____

Relationship to client

Garden State Speech Therapy

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All Information Will Remain Confidential

Patient's name_____

Name on card: _____

Billing Address: _____

Credit Card Type: _____Visa _____Mastercard _____Discover

Credit Card Number: _____

Exp. Date:_____ CVV/Security Code:_____

____ I choose to pay my outstanding balance with a credit card. A valid credit card is required to be on file for this option. Please provide the following information.

____ I understand that all balances more than 30 days overdue will be charged to my credit card on file

I hereby authorize Garden State Speech Therapy, LLC to charge the credit card listed above for services rendered. I agree that all sessions booked will be charged at the corresponding rate as stated in the Service Agreement. I agree to keep valid credit card information on file with Garden State Speech Therapy, LLC and to immediately notify Garden State Speech Therapy, LLC if there are any changes to my credit card information. I agree to pay these charges according to my credit card agreement and not to cancel any valid charges, according to this agreement.

_____ _____

Signature Date