Garden State Speech Therapy

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 SWALLOWING INTAKE FORM

Name: _____ Date of Birth: _____

Address:_____

_____

Phone: _____

Name and address of professional who referred you to this clinic:_____

_____

Would you like GSST to share the results of the evaluation with your primary care

provider/referring physician: YES NO

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HISTORY OF PROBLEM

Please describe swallowing difficulties:

_____

_____

START OF SWALLOWING DIFFICULTY

When did swallowing difficulty start? _____

Did swallowing difficulty start:

_____ Gradually _____Suddenly

Please describe:

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_____

_____

_____

Previous speech or swallowing therapy? _____Yes _____No

Please describe:_____

_____

_____

Previous Modified Barium Swallow Study (MBSS)? _____Yes _____No

Date: _____ Location: _____

Results:_____

_____

Previous Fiberoptic Endoscopic Evaluation of Swallowing (FEES)? _____Yes _____No

Date: _____ Location: _____

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Results:_____

_____

CURRENT STATUS

What is the consistency of food and liquid that you are currently eating?:

Solids: _____Regular _____Soft _____Puree

Liquids: _____Thin/Regular _____Nectar-thick _____Honey-thick

___Nothing by mouth (NPO)

If you checked NPO: Do you have a feeding tube? ____Yes ____No

Date placed: _____

Dentition/Teeth: _____Natural _____Dentures (upper/lower/both)

_____Bridge _____Missing teeth _____No teeth

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Please describe:_____

Do you require assistance with your meals?: _____Yes _____No

If yes, please describe:

_____

_____

Please check the problems you are currently experiencing (check all that apply):

____drooling during non-mealtimes

____losing (food/liquid/both) from your mouth during meals

____difficulty drinking from a straw

____difficulty chewing

____difficulty moving (food/liquid/both) out of mouth and into throat

____difficulty starting the swallow

____pain during swallowing

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____(food/liquid/both) coming out of nose

____coughing/choking on (food/liquid/both)

____after swallowing, frequent (throat clearing/coughing/both)

____sneezing during meals

____runny nose during meals

____eye watering during meals

____sensation of food sticking (throat/chest/both)

____difficulty swallowing pills

____need to avoid certain (foods/liquids/both)

____regurgitation or being unable to keep down certain (foods/liquids/both)

____burping (during/after/throughout) meals

____coughing or choking on saliva during non-mealtimes

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____sudden coughing after lying down

____waking at night choking or coughing

____thickened or excess mucus or secretions

____ulcers or sores in mouth

____dry mouth

____unpredictable or variable voice quality during the day

Have you had recent weight loss?: _____Yes _____No

If yes, _____# of pounds over _____weeks/months

Describe your appetite: _____Good _____Fair _____Poor

Dietary restrictions or foods you eliminated: _____Yes _____No

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If yes, please state: _____

Food allergies: _____Yes _____No

If yes, please state: _____

Length of meal time: ___less than 20 min ___20-30 min ___greater than 30 min

Any strategies that help you swallow?: _____Yes _____No

If yes, please describe: _____

Please describe your voice: ____Normal ____Hoarse ____Breathy ____Weak ____No voic

Current physical status: _____Walk _____Cane _____Wheelchair

Current Medications: _____

_____

_____

PERTINENT MEDICAL HISTORY

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Reflux/Gastroesophageal reflux disease (GERD)/Laryngopharyngeal reflux (LPR)

_____Yes (please circle which) _____No

Esophageal disorder: _____Yes _____No

If yes, please explain: _____

History of aspiration pneumonia: _____ Yes _____No

If yes, date: _____

Neurological deficits: _____Yes ____No

If yes, please explain: _____

Heart problems/disorders: _____Yes _____No

If yes, please explain: _____

Lung/breathing disorders: _____Yes _____No

If yes, please explain: _____

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Head/Neck Cancer: _____Yes _____No

If yes: Location, type and date of diagnosis

_____

_____

Surgery and dates

_____

_____

_____

_____

Chemotherapy/Radiation (Circle one or both) Current/Completed (Circle one)

Duration/Dates:_____

Please provide any additional information that you feel will help us understand your

swallowing problem or any goals you may have:

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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

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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