# 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

## Intake Form: Adult Fluency

Name: ____________________________________________

Date of Birth:_________________ Gender: _________ Age: ________________

Address: ____________________________________________ City: ____________________

State: _______________ Zip: ____________

Email address: _____________________________________

Highest degree held: ________________________________

Current occupation: ________________________________________________________

Primary language: __________________ Other languages:_______________________

What brings you into the clinic?

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Referred by: ________________________________________________

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

provider/referring physician: YES NO

History of Stuttering:

Is there a family history of stuttering? ____Yes _____No
If so, who?

______________________________________________________________________

______________________________________________________________________

What age did you begin stuttering?___________________________________________

Please describe your first memory of stuttering:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Did your parents talk with you openly about stuttering? _____Yes _____No

Please Describe:

Can you recall your early stuttering patterns? (For example, repeating part of a word, repeating a word, repeating a whole sentence, prolongation of sounds, etc.) If so, please describe:

How has your stuttering changed since you were a child?

How would you describe your stuttering pattern at present?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Do you experience any physical behaviors that may be associated with the stuttering:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Do you experience any of the following:
_______ Head movement _______ Eye blinking _______ Postural changes
_______ Tongue clicking _______ Tongue protrusion _______ Lip licking
_______ Making unusual noises with your teeth
_______ Movement of extremities (foot tapping, hand tapping)
_______ Eye movement (side to side, eye rolling)
_______ Other

Do you feel tension when speaking? Please indicate in what area(s) you feel tension:

_______ Lips

_______ Jaw

_______ Larynx/Throat

_______ Chest

_______ Abdomen

_______ Hands, arms, legs

_______ Other: ______________________________________________________________

In which of the following ways do you experience difficulty with breathing and breath support when speaking? Please check all that apply:

_______ Holding your breath
_______ Running out of breath
_______ Taking multiple breaths
_______ Inhaling in the middle of a sentence
_______ Exhaling before speaking
_______ Gasping
_______ Speaking on exhausted breath
_______ Breathing noisily
_______ Breathing forcefully

In what situations is your speech the most difficult? The easiest? Please describe:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

With which people is your speech the most difficult? The easiest? Please describe:

______________________________________________________________________
______________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Do you ever anticipate moments of stuttering? (Please circle):

Consistently Frequently Sometimes Seldom Never

What words or speech sounds trigger anticipation of moments of stuttering?

_______________________________________________________________________________

_______________________________________________________________________________

Who are you open with about your stuttering? Please check all that apply:

_______ spouse _______ family _______ co-workers _______ friends

_______ acquaintances _______ I prefer not to discuss my stuttering with others

How do you perceive others' reactions to your stuttering? How do these perceptions impact your speech?

How do you perceive yourself as a communicator (not just in regards to your speech, but your overall ability to effectively convey what you're thinking to others)?

**Medical- Psychological History:**

Are you currently taking any medications?

Have you ever had a severe injury to the head?

Have you ever received psychotherapy?

Have you had a history of seizures?

______________________________________________________________________

______________________________________________________________________

Have you ever had any body tremors/uncontrollable tics not associated with stuttering?

______________________________________________________________________

______________________________________________________________________

Is there anything else we should be aware of?

______________________________________________________________________

______________________________________________________________________

Previous Therapy:

Date: ______________________________

Where:

______________________________________________________________________

Length:

______________________________________________________________________

Type of therapy (if known):

______________________________________________________________________

What were the most effective aspects of therapy? _____________________________________

______________________________________________________________________

______________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

What were the least effective aspects of therapy?

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Did you see success outside of clinic? _____Yes _____ No

Please describe:______________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Are you currently using tools from therapy? If so, please describe:______________________

_______________________________________________________________________________

_______________________________________________________________________________

Why was therapy terminated?

Given that you have decided to pursue therapy, what outcomes would you like to see?

Is there anything else you would like us to know about your stuttering or your life experience with stuttering?

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

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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