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 VOICE 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

Primary Voice Complaint/Concern: _____

_____

How long has this voice concern lasted? _____

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SPEECH THERAPY

Vocal Hygiene

Caffeine Intake (glasses/cups per day of coffee, tea, soda, etc.): _____

Water Intake (8 oz. Glasses per day): _____

Allergies: _____

Hours per day spent speaking: _____

School/home environment (noise level, exposure to irritants):

_____

Please check all significant medical diagnoses and conditions:

Diagnoses/Condition	Date	Diagnoses/Condition	Date
☐ GERD (Gastro-esphageal reflux)		☐ Asthma	
☐ Premature birth		☐ Frequent colds	
☐ Sleep apnea		☐ Ear infections	
☐ Cardiac conditions (please specify)		☐ Other: _____	
☐ Seizure disorder		_____	
☐ Diabetes		_____	

Please list all significant surgical procedures and hospitalizations:

_____

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_____

_____

_____

Please list all current medications, vitamins, and/or supplements:

Medication	Dose	Frequency	Route

Vocal Use (check all that apply):

- ☐ Shouting
- ☐ Yelling
- ☐ Speaking Loudly
- ☐ Singing
- ☐ Excessive Talking
- ☐ Drama/Theatre
- ☐ Public Speaking
- ☐ Throat Clearing
- ☐ Coughing
- ☐ Other: _____

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My/my child's voice can be described as (check all that apply):

- ☐ Hoarse
- ☐ Breathy
- ☐ Strained
- ☐ Raspy
- ☐ Pushed
- ☐ Quiet
- ☐ Loud
- ☐ Hard to Project
- ☐ Scratchy
- ☐ Monotone
- ☐ Low Pitch
- ☐ High Pitch
- ☐ Other: _____

Medical History

Please list any medical diagnoses.

Medical Diagnosis: _____

When made: _____

By Whom: _____

Medical Diagnosis: _____

When made: _____

By Whom: _____

Please add a separate sheet for more diagnoses.

Please list any previous and current voice or respiratory problems and/or diagnoses.

Voice/Respiratory Diagnosis: _____

When made: _____ By Whom: _____

Voice/Respiratory Diagnosis: _____

When made: _____ By Whom: _____

Please add a separate sheet for more diagnoses.

Have you/your child ever been assessed by an Ear, Nose and Throat specialist (also called an Otolaryngologist)?

No ____ Yes ____

If Yes, when: _____

Name of specialist: _____

Reason for consultation:

_____

_____

Do you/your child suffer from reflux (e.g., take antacids, taste stomach acid in mouth, sit up in the middle of night, belch frequently)?

No ____ Yes ____

If yes, are you currently taking any medication to treat reflux? No ____ Yes ____

If yes, what is the name of the medication? _____

Was reflux diagnosed by a medical professional? No ____ Yes ____

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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