PATIENT INFORMATION

Name: _____ DOB: _____

Address:_____
_____Zip:_____

Email address: _____

Phone: (home) _____
(cell) _____
(work) _____

Emergency Contact: _____ Phone #: _____

Person completing this form: _____ Relationship to Patient: _____

Reason for referral / Primary concern:
_____
_____

Attending physician's name: _____ Phone:_____
Address: _____ Zip: _____

Do you have a prescription/letter of recommendation from physician? Yes No

Do you have a report from physician? Yes No therapist? Yes No

How did you find us? (circle)
Physician Friend Insurance Internet School Other_____
_____

Person responsible for payment:
Name: _____ Phone: _____

Address: _____ Zip: _____

SS#: _____

Adult Case History

General Information

Name: _____ Date of Birth: _____
Occupation: _____
Single:_____ Widowed:_____ Divorced:_____ Spouse's Name: _____

What languages do you speak? If more than one, list the dominant language first: _____
_____

What was the highest grade, diploma, or degree you earned? _____

Describe your speech/communication difficulties: _____
_____
_____
_____
_____
_____

What do you think may have caused the problem? _____
_____
_____
_____
_____
_____

Have you seen any other speech-language specialists? Who and when? What were their conclusions or recommendations? Please provide any reports you may have. _____
_____
_____
_____
_____

Have you seen any other specialist? (physicians, audiologists, psychologists, neurologists, etc.) If yes, indicate the type of specialist, when you were seen, and the conclusions or recommendations. Please provide any reports you may have. _____
_____
_____
_____
_____

Are there any other speech, language, or hearing problems in your family? If yes, please describe:
_____
_____
_____
_____
_____

Medical History

Provide the approximate ages at which you suffered the following illnesses and conditions:

Adenoidectomy_____	Asthma_____	Chicken Pox_____
Colds_____	Croup_____	Dizziness_____
Draining ear, etc_____	Ear infections_____	Encephalitis_____
German Measles_____	Headaches_____	Hearing loss_____
High fever_____	Influenza_____	Mastoiditis_____
Measles_____	Meningitis_____	Mumps_____
Noise exposure_____	Otosclerosis_____	Pneumonia_____
Seizures_____	Sinusitis_____	Tinnitus_____
Tonsillectomy_____	Tonsillitis_____	Other_____

Do you have any eating or swallowing difficulties? If yes, describe: _____

_____

_____

_____

_____

List all medications and vitamins you are currently taking: _____

_____

_____

_____

Describe any major surgeries, operations, or hospitalizations (include dates): _____

_____

_____

_____

Describe any major accidents: _____

_____

_____

_____

Provide any additional information that might be helpful in the evaluations or remediation process:

_____

_____

_____

_____

_____

Person completing form: _____

Relationship to patient: _____

Signed: _____ Date: _____

SCHEDULING PAYMENT AND INSURANCE POLICIES

Scheduling:
Your scheduled therapy time is a reserved time for you and your therapist. Your therapist spends a great deal of time and effort preparing for your therapy session. If you must cancel a therapy session, we ask that you give at least 24 hours notice. ***Less than 24 hours notice for cancellations (last minute cancellations) and not showing up for an appointment (no shows) will be charged a $40 fee. These charges will not be filed with your insurance company and will be your full responsibility for payment.***

Consistency in therapy attendance is absolutely necessary for you to make progress. If you find it necessary to cancel therapy sessions frequently, we will ask that you schedule therapy at a more convenient time so that therapy may be provided on a consistent basis.

If you should need to cancel your appointment for 3 of 5 scheduled appointments, or no show more than 2 times, you will automatically be removed from the schedule and put on a wait list for a time easier for you to attend consistently.

There will be times when your therapist will need to cancel therapy. You will have an opportunity to re-schedule the session or cancel the session.

Therapy sessions are scheduled back to back throughout the day. We try to begin and end therapy promptly. Please be on time for your appointment. If you are late for an appointment, it will be necessary to shorten you therapy visit.

Any questions or concerns you may have regarding your therapy or other issues of the office may be directed to Susan Weber. You may reach Susan by phone 512-331-4115 or by email at sweber@austinctg.com.

_____

Signature Date

Payment:
Payment is due at the time services are rendered. You may choose to pay weekly or monthly if you make arrangements with the front office. Fees owed past 30 days will need to be paid immediately or your appointments will be cancelled until payment is received.

Payment is due in full for all services rendered until insurance coverage is verified. Once insurance coverage is verified, you will be expected to pay your co-pay weekly. If payment is not received from your insurance company within 60 days of billing, you will be responsible for payment in full.

If Capital Therapy Group is filing insurance claims for you or if you are paying privately, a statement will be provided to you for any balance due by you. Please note there will usually be a 4 to 8 week delay between the date services are rendered and the response from your insurance company. This delay is due to the time it takes your insurance company to process claims filed. Therefore, your statement will reflect this delay if you have not paid your balance in full. Questions regarding insurance claims, charges and payments should be directed to Sylvia Johnson by phone at 512-331-4115 or by email at sjohnson@austinctg.com.

_____

Signature Date

Insurance:
Insurance is a contract between you and your insurance company. Capital Therapy Group will file insurance claims and provide assistance in filing necessary paperwork when claims are denied but ultimately terms of reimbursement are between you and your insurance company. If for any reason, insurance does not reimburse at the anticipated rate, the patient is responsible for all expenses incurred.

If you change insurance companies, it is your responsibility to let the office know of the change and to provide a copy of the new insurance card on or before that new coverage begins. Failure to give the necessary information on or before coverage begins, may result in your responsibility for all fees incurred for services provided during that time. Questions regarding your coverage, benefits and denials should be directed to your insurance company.

_____

Signature Date

Person Completing this Form: _____

Relationship to Patient: _____

Patient's Name: _____
DOB: _____

Authorization for releasing and acquiring information:
I, the undersigned, authorize Capital Therapy Group to acquire and/or release professional information from and to my physician and/or other personnel involved in the evaluation and management of requested services.

_____
Signature

_____
Printed Name/ Relationship to Patient

_____
Date

Authorization for audio recording and/or videotaping:
I grant permission to be videotaped and/or audio recorded during a therapy session. I understand that this video/audio recording will be used to establish baseline criteria and may be analyzed at any time by the treating speech therapist, occupational therapist, or physical therapist. Audio and/or videotaping with *will not be shared with any other parties and will only be used for the purpose of analyzing skills for therapy goals.*

_____
Signature

_____
Printed Name/Relationship to Patient

_____
Date