BACKWAY'S PHYSICAL THERAPY, PLLC: Speech & Language Therapy Self-Pay Client Information Form

Welcome to our Practice! ***Sorry these forms are lengthy**, but they will assist us in fully evaluating your condition and establishing a meaningful treatment plan for you. Please fill them in to the best of your ability.*

NAME____**AGE**_____**BIRTHDATE**__________**HT**_____**WT**_____**SEX**____
ADDRESS____**CITY**________________**STATE**_____**ZIP**_________
Phone: Home____________________________ **Work**__________________ Ext_______ **Cell** ___________________________
Email: ____ **PROFESSION**__________________________
MARITAL STATUS: S M W D Sep. **Spouse's Name**____
YOUR SOC. SEC.#_______-______-_________ **SPOUSE'S SOC. SEC.#**_______-______-_________

EMERGENCY CONTACT: Name: ____________________________________**Phone#**______________________________

RESPONSIBLE PARTY (If not you, who will be responsible for paying the bill?)

Name____ Relationship To You_____________________________________
Address____Zip_____________
HomePhone#_______________________________WorkPhone#__________________________Ext________________________

DOCTORS' NAMES & PHONE #	
1ST Dr.	2ND Dr.
Phone #	Phone #

We believe that patients who understand and participate in their health care will achieve the best results.
We respect your individuality, your rights, and your privacy, and we will give you the best care we possibly can.

Please read the following and sign below.

Self-pay client waiver of insurance use:

I am, or my dependent is, entering into care as a "self-pay" client. By signing this agreement, I am stipulating that, even if I currently have health insurance or other insurance benefits that might cover my care, I am choosing not to use those benefits for Physical Therapy or Speech Therapy received at Backway's Physical Therapy, and I am directing the Backway's Physical Therapy staff **not to bill** any insurance on my behalf.

I understand that, if I choose to utilize my insurance benefits at a later date: this cannot be done retroactively; this can only be applied to future dates of service; I must give the treating practitioner at least 48 hours notice, and I must provide the proper medical authorization. Additionally, I understand that changing from a self-pay client to an insurance-based client will necessitate filling in new forms and may necessitate my undergoing a new evaluation procedure to establish medical necessity. **(_____ initials)**

Authorization to leave Messages: In the event that Backway's Physical Therapy cannot speak to me in person regarding the appointments or evaluation results, I give permission to Backway's Physical Therapy to contact me and leave a message on *(check all that apply)*: **(_____ initials)**

Answering Machine ___________ Cell Phone ____________ or other location____________________

Payment: I understand that each visit is to be paid for at the time of the visit, unless prior arrangements have been made. I also understand that no one will be denied medical care if they do not have sufficient funds at the time of the visit. However, payment for such visits is expected in full within 10 (ten) days of the visit, ***whether or not I receive an invoice from you***. Payments may be made by cash & check, or by credit card **with an added $5 PayPal fee**. If I cannot pay my account in full, I agree to make a payment plan with your office staff **and adhere to it**. If my account becomes overdue, I will be charged late fees (see page 8). **(_____ initials)**

Cancellations: I understand that I will be charged for an appointment which I miss and do not cancel before 8AM of the day **prior** to my scheduled appointment. **(_____ initials)**

I have read the information above, and understand it. I hereby consent to treatment by Backway's Physical Therapy, PLLC.

Signed____**Date**________________________________

Speech and Language Therapy: **Initial Questionnaire:** **<u>Present</u> <u>Problems</u>**

It is important that you inform us of ***<u>ALL</u>*** *medical/health conditions at your first appointment, and immediately inform us of any changes in your medical/health condition during your course of treatment.*

The following forms *will tell us about your health conditions, medications, your insurance & contact information. Some of the forms ask for your signatures to give us permissions for billing, treatment, and communication purposes; and for signatures to indicate that you understand how your insurance, our billing, and the Privacy Act (HIPAA) work.*

Please answer these questions to the best of your ability. If something is confusing, leave it blank.

Information About What Brought You Here:

How did you hear about our services? ____

What are the main symptoms that bring you to Speech Therapy today? ______________________

____

Are you seeking treatment for? (Please circle all that apply)

SPEECH VOICE SWALLOWING COGNITION APHASIA (language trouble)

Onset: When did your symptoms begin? ____

Was the onset sudden or was the onset gradual? __________________

Previous Treatment: Have you had any previous **Speech Therapy** treatment for these symptoms?

Yes _____ No _____ If "yes," please describe________________________________

Other Services:

Have you received <u>any</u> **physical therapy, speech therapy, home health <u>or</u> hospice care services in the past year?** Yes _____ No _____ If yes, when? ______________________

Please explain: ____

____

Please give names of *<u>all</u>* other Health Care Professionals you are seeing:

(Example: name of your Physical Therapist, Occupational Therapist, Psychologist, ENT, etc.):

____

____

Previous Level of Function: What were you able to do before these symptoms began, that you cannot do now?

____

____

Goals: What results do you want from Speech Therapy? __________________________________

____

Symptoms:

Please indicate on the scale below the intensity of your symptoms or pain:

0 1 2 3 4 5 6 7 8 9 10

◆————————————————————◆

None Mild Moderate Intense Severe Intolerable

Patient name: ______________________________ Date: ___________

Speech & Language Therapy: Initial Questionnaire: *Health History*

Please indicate if you now have, or in the past had, any of the following (check all that apply):

Voice & Speech
- ☐ Slurred / Mumbled Speech
- ☐ Voice Problems or Changes
- ☐ Naming Problems
- ☐ Difficulty Understanding
- ☐ Illegible Writing
- ☐ Other: *(write in any other complaint)*

Nervous System
- ☐ Head / Traumatic Brain Injury
- ☐ Stroke /TIA's
- ☐ Memory Loss
- ☐ MS
- ☐ Parkinson's
- ☐ Alzheimer's Disease
- ☐ Dementia
- ☐ Peripheral Neuropathy
- ☐ Epilepsy / Seizure Disorder
- ☐ other Neurologic problems *(list)*

Respiratory System
- ☐ Asthma
- ☐ Emphysema or COPD
- ☐ Pneumonia
  How Recently? ___________
- ☐ Sinus surgeries
- ☐ Allergies
- ☐ other Lung problems *(list)*

Cardiac / Circulation System
- ☐ Heart Attack
- ☐ Angina or Chest Pain
- ☐ Irregular Heart Rhythm
- ☐ Anemia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Surgery
  When _________________
  What __________________

Digestive & Eliminatory
- ☐ Swallowing Problems
- ☐ Changes in Appetite
- ☐ Unexplained Weight Change
- ☐ GERD / Heartburn / Reflux
- ☐ Esophageal Dysmotility/Strictures
- ☐ History of Feeding Tube
- ☐ Disordered Eating
- ☐ Difficulty Chewing
- ☐ IBS
- ☐ Frequent Loose Stools
- ☐ Frequent Constipation
- ☐ Hiatal Hernia
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Urinary Incontinence

Endocrine & Immune System
- ☐ AIDS
- ☐ HIV positive
- ☐ Hepatitis A B C (circle)
- ☐ Diabetes Type 1 or 2 (circle)
- ☐ Thyroid Imbalance
- ☐ Low Blood Sugar
- ☐ Head and Neck Cancer
- ☐ Cancer (other)

Please describe:

Musculoskeletal & Connective Tissue Conditions
- ☐ Osteoarthritis
- ☐ Spinal Stenosis
- ☐ Herniated Disc Neck
- ☐ Osteoporosis or Osteopenia
- ☐ Compression Fractures
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Gout
- ☐ Fibromyalgia
- ☐ Migraine
- ☐ Frequent Headaches
- ☐ TMJ
- ☐ Teeth Grinding
- ☐ Other: *(list)*

General Challenges
- ☐ Falls. If yes, more than 2 in a year? ☐
- ☐ Shortness of Breath
  - ☐ on exertion ☐ at rest
- ☐ Dizziness
- ☐ Balance Disturbance
- ☐ Hearing Loss
- ☐ Vision Loss
- ☐ Sleep Apnea
- ☐ Insomnia
- ☐ Unusual Fatigue
- ☐ Alcoholism
- ☐ Substance Abuse (current or past)
- ☐ Clinical Depression
- ☐ Mental or Emotional disorders

Please Explain:

Surgeries, Traumas, Other Illnesses, Accidents & Hospitalizations:

Please list any other information regarding your medical or health history that you believe we should know.

*Please include approximate dates **or** your age at the time.*

Thank you *for providing this information for us. Please, let us know of any health changes.*

Patient name: ___________________________________ Date: ___________

Backway's Physical Therapy: Intake Form Patient Medication List & Recent Fall History

Have you fallen in the past 12 months? ☐Yes ☐No **How many times?** _______ **Were you injured from falling?** ☐Yes ☐ No

Please look at the labels on your medications & supplements; then list them below. This includes all prescription, over-the-counter, herbals, vitamins, minerals and dietary/nutritional supplements you take routinely, and/or on an as-needed basis.

Medication or Supplement Name	**Dosage**	**How many times/day?**	**Is this taken by mouth or other route?**	**What condition is this for?**	**"May cause dizziness" label on it?**	**Does this med make you dizzy?**
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No

Therapist notes: Is form complete? ☐ Yes, ☐ No. If no, reason not completed: ☐ Pt refused ☐ Emergency ☐ Pt cog unable **(initials:** ________)

Patient Name: ____ **Date:** __________________

Backway's Physical Therapy, PLLC **SELF PAY – Authorizations & Office/Financial Policy Form**

You have the right to revoke the following authorizations, unless we have already taken action relying on the authorization. Requests to revoke any authorizations must be made in writing. ____________ (please initial)

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***Optional*: Consent for Use of Information for Presentations, Research and/or Publications (optional)**

I grant permission, now and in future, to Backway's Physical Therapy, or their duly appointed representative, to use my records, or those of my dependent, for other consultations and for professional education, research and publications, **providing reasonable precautions are taken to guard against the disclosure of the client's identity**. My signing of this authorization is **not** a condition to receive treatment by Backway's Physical Therapy personnel.

(Optional) Patient's/Guardian's Signature ________________________________Date ____________

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All Authorizations below are Mandatory:

Receipt of HIPAA Patient Privacy Notice: My signature below indicates that I have received the HIPAA Patient Privacy Notice. I consent to your use and disclosure of protected health information about me for treatment, payment, health care operations, and/or as required by law and by HIPAA. **(_____ initials)**

Consent for Treatment: I hereby authorize the professional staff of Backway's Physical Therapy to evaluate and treat me or my dependent. During the course of evaluation and treatment, I authorize the licensed personnel at Backway's Physical Therapy to use any and all techniques they have been trained to use, which they believe will benefit me, in order to help me recover. I have the right to refuse a specific technique or form of treatment, if I so choose. **(_____ initials)**

Consent for Mutual Exchange of Information: I authorize the mutual exchange of information regarding myself, or my dependent, between the Backway's Physical Therapy staff members, and all professional practitioners involved in my healthcare, or that of my dependent, at any time (i.e. doctor, chiropractor, counselor, etc). Your office may also talk with the non-practitioner persons listed below about my health information: **(_____ initials)**

□ Spouse	Name:	phone#:
□ Child	Name:	phone#:
□ Parent	Name:	phone#:
□ Other	Name:	phone#:
□ Other	Name:	phone#:

Missed appointments: No-Shows; Frequent Cancelations & Cancelations Without Adequate Notice:
If I need to cancel an appointment, I must let you know before 8AM of the day prior to my scheduled appointment to avoid a cancelation fee. *If I cancel late*, or if I do not attend my appointment, **I will be charged** a missed-appointment fee which may be equal to the full treatment session price. **(_____ initials)**

Overdue Accounts: All overdue accounts are subject to late fees (table below). Self-pay accounts start accruing fees 30 days after service is rendered. Liens start accruing fees 90 days after discharge from therapy.

Past Due Balance	$20 - $100	$101 to $750	$751 to $3000	Greater than $3000
Monthly Late Fee	$15	$25	$50	$75

Returned check fee: A fee of $25 is charged on all returned checks.

Collections: Returned checks and failure to pay account balances overdue for 90 days may result in our referring your account to an outside collection service. **(_____ initials)**

We may refuse service to a client under certain circumstances. Refusal is usually due to, but is not limited to: non-payment of past accounts; repeated missed/canceled appointments; inappropriate behavior; and the therapists' opinion that our services won't benefit a client or aren't medically necessary. **(_____ initials)**

I have read and fully understand the above statements and agree that they apply to all treatments that I receive at Backway's Physical Therapy. I agree to pay for all services rendered at the time of service, unless previous arrangements have been made.

➔Patient's/Guardian's Signature ______________________________________ Date ____________

Patient's Printed Name: ____ *(ST: Self-Pay Initial Forms Page 5 of 5)*