T

Patient Information:

Last Name: First Name: Middle Initial:

Address: Apt. #

City: State: Zip Code:

Home Phone: Work Phone:

Cell Phone: Fax:

Email Address:

Patient's Date of Birth: Parent SSN: Patient's Sex ○ M ○ F

Guarantor Name:

Primary Insurance Information:

Insurance Company:

Subscriber #: Group #:

Name of Insured: D.O.B. of Insured:

Employer of Insured: Work Phone:

Employer Address:

Work Status (Check one): ○ Full Time ○ Part Time ○ Retired ○ Unemployed

Secondary Insurance Information:

Insurance Company:

Subscriber #: Group #:

Name of Insured: D.O.B. of Insured:

Employer of Insured: Work Phone:

Address of Employer:

Work Status (Check one): ◯ Full Time ◯ Part Time ◯ Retired ◯ Unemploye

Emergency Contact Information:

Name: Relationship:

Home #: Cell #:

Address:

Did your current physician refer to you? ◯ Yes ◯ No

Current Physician:

Address:

Phone No: Fax:

If no, please provide the following information:

Name of referring Physician (if applicable):

Address of referring Physician:

Contact phone # of referring Physician:

Were you referred to us by someone else or did you hear about us from another source? If yes, please let know from where:

I authorize Speech Therapy Plus, pllc. to bill my insurance company. I understand that I am financially responsible for charges, whether or not paid for by my insurance. I hereby authorize the release of all information necessary to secure payments of benefits. I authorize the use of this signature on all insurance submissions.

Signature: Date:

Speech Therapy Plus, pllc.
1421 FM 359, Suite H
Richmond, TX 77406
(281) 232-1900
Team@Speechtherapyplus.com

Adult Patient Medical History Form

Family Information:

Are you...? ◯ Singl ◯ Marriec ◯ Partnei ◯ Seperatec ◯ Divorced ◯ Widowec

List members of Immediate Family

Name	Age	Relationship	Health Problems

Work History:

Are you currently employed outside the home? ◯ Yes ◯ No

If not, are you ◯ Retirec ◯ Disable

Present type of work: _____

At work, are you exposed to: ☐ harmful toxins ☐ heavy lifting ☐ extreme temperatures ☐ undue stress ☐ other potential hazards

Current Medical History:

Are you having any medical problems? ◯ Yes ◯ No

If yes, please explain _____

Has your vision ever been tested?	◯ Yes	◯ No
Do you wear glasses?	◯ Yes	◯ No
Do you think you may have a vision problem?	◯ Yes	◯ No
Has your hearing ever been tested?	◯ Yes	◯ No
Do you wear a hearing aid?	◯ Yes	◯ No
Do you think you may have hearing problem?	◯ Yes	◯ No

Family History: tf patient or family member has or has had any of the following problems, mark as indicated below and explain in the space provided:

P-Patient M-Mother F-Father GM-Grandmother GF-Grandfather A-Aunt U-Uncle

chronic illness:

allergies:

speech problem:

hearing problem:

swallowing problems:

asthma/lung problems:

respiratory infections:

tuberculosis:

immunity problems/HIV:

high blood pressure:

heart attack:

intellectual disability:

drug/alcohol use:

stroke:

cancer:

seizures:

mental illness:

other:

Additional Comments:

Please list below all illnesses, injuries and operations:

1) Type: Date:
Complications: Treatment:
Physician:

2) Type: Date:
Complications: Treatment:
Physician:

3) Type: Date:

Complications: Treatment:

List all Present Physical Disabilities:

Current Medications and Purposes:

Are you allergic to any Medications? ◯ Yes ◯ No

If yes, please list medications and their reactions:

Are you allergic to any Foods? ◯ Yes ◯ No

If yes, please list foods and their reactions:

Social History:

Hobbies:

Sports:

What is your primary goal to achieve through Occupational Therapy services?

If there is any additional information that you feel would be important for your provider to be aware of, please explain:

Speech Therapy Plus, pllc.
1421 FM 359, Suite H
Richmond, TX 77406
(281) 232-1900
Team@Speechtherapyplus.com

General Consent of Treatment

I authorize Speech Therapy Plus to provide speech therapy evaluations and treatment services as long as the a therapisUpatient relationship exists or until I withdraw my consent' _____ (Please initial)

Consent for Gonsultation Services

I authorize Speech Therapy Plus, PLLC., it's provide(s) and/or other designated office staff, to share and consult with other providers (such as PCP, specialist doctors and other speech therapists) in order to allow and promote the continuity of care. _____ (Please initial).

Observation Consent

I authorize and give consent to receive treatment under the observation of a student either currently enrolled in an Occupational Therapy curriculum program or one considering an OT career. _____ (Please initial).

Consent for Voicemail and Text Notifications

As a service to our patients, Speech Therapy Plus may need to make important calls/texts regarding appointments or other speech therapy related information that may need to be place on your auto.messaging system. The information may include protected health information. By initialing thas notice, you consent to receiving such calls/ texts at the phone number you have provided to us. _____ (Please initial).

Speech Therapy Plus, pllc.
1421 FM 359, Suite H
Richmond, TX 77406
(281) 232-1900
Team@Speechtherapyplus.com

Consent for Release of Information

I authorize Speech Therapy Plus, pllc., it's provide(s) and/or other designated office staff, to release and obtain clinical information for _____ (patient) as it relates to the treatment, authorization for treatment and for the purposes of insurance reimbursement. I understand this information may be shared with insurance companies, physicians' offices and/or other required medical/educational offices as it relates to the treatment of this patient. If you have someone that you want your information shared with, please list the name(s), relationship to you, and phone number of that person(s) here:

_____

_____ (Please initial).

Privacy Notification

I have received a copy of Speech Therapy Plus' privacy policy. I have read and understand this information as it relates to my rights and protections under the federal health information privacy law. I also understand that I may ask questions at any time regarding my privacy rights as it pertains to services provided by Speech Therapy Plus _____ (please initial).

I have read each of the above statements and I understand it contents. I understand I have had an opportunity to ask questions regarding any of thcae policies before providing consent. Therefore, I hereby agree and consent to all these statements and policies of Speech Therapy Plus. _____ (please initial)

Patient Name _____

Patient Signature _____

Date _____

Speech Therapy Plus, pllc.
1421 FM 359, Suite H
Richmond, TX 77406
(281) 232-1900
Team@Speechtherapyplus.com

11/08/2021

Dear Parents/Patients,

Please be aware we are enforcing and updating our therapy “No Show Attendance” Policy. When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient. We understand that things happen. Therefore, it is important that you call the office within 4 hours in advance to cancel or reschedule your appointment. If for any reason, you need to cancel an appointment, please notify our office as soon as possible. Our therapists are paid “per visit” so they count on you keeping your appointments.

Effective immediately, any patient that does not show up for their scheduled appointment or cancels their appointment less than 4 hours in advance, will incur a $35 charge to their account. Payment of this charge will be required prior to your next scheduled appointment.

We ask that you please sign below and return to our office reflecting your acceptance of this policy. For Medicaid patients, please acknowledge that you waive the “no fee” restriction.

Thank you for choosing Speech Therapy Plus!

I have read the above and understood Speech Therapy Plus, PLLC’s “No Show Attendance” Policy.

Patient/Legal Guardian

Signature Date

Patient Name – Please print

Speech Therapy Plus, pllc.
1421 FM 359, Suite H
Richmond, TX 77406
(281) 232-1900
Team@Speechtherapyplus.com

Credit Card Authorization Form

In order for us to process your credit card paynent(s), please complete this form.

Patient Name:

Card holder name, if different than patient;

Card holder address:

Card holder city, state, zip:

Card holder phone:

Credit card type (select one):

Credit card number:

Expiration date:

CVS Security Code (3 digit number on back of card)

Name as it appears on Credit Card

Statement of Authortzafion
Confidentlal Informatlon

To; Speech Therapy Plus,

I agree to pay for Speech Therapy Treatments for the above named patient on each date services are rendered. I agree to pay the amount determined by insurance or the $70.00 private pay amount per session.

Speech Therapy Plus is authorized to charge the cost of therapy services to my credit card as stated.

Cardholder Signature: **Date:**