Your Speech, Language, and Hearing History

The following information helps us tailor therapy to your unique needs. Thank you for taking the time to complete this form.

Today's Date_____

Name _____ Date of birth: _____ Age: _____

Male ◯ Female ◯

Address_____
Street City State Zip

Email_____

Phone_____
Home Work Cell

Have you been evaluated for this before? YES ☐ NO ☐

If yes, where?_____ When? _____

Referred by _____

Reasons for Referral _____

Primary Insurance Name & Member ID Number: _____

Secondary Insurance Name & Member ID Number: _____

Insurance Policy Holder Name: _____

Insurance Policy Holder Date of Birth: _____ Relation to patient: _____

Insurance Policy Holder's Social Security Number for TRICARE ONLY: _____

Family

1. Where do you live? With whom?

2. What language(s) do you speak? Which is stronger?

Medical

1. List any past hospitalizations, major surgeries, accidents or illnesses.

2. List any medications you take.

Education

1. What is the highest level of education you earned?

History of Problem

1. Describe your speech or language problem.

2. Do you know what caused the speech problem? If so, what?

3. Has the problem improved or worsened at all?

4. Was the problem sudden or did it develop over time?

5. Does this problem cause any concerns with your family members, co-workers, etc.?

6. Are there any conditions that make the problem better or worse?

7. What strategies have you used in the past to overcome the problem?

8. Have you ever received any professional help from a speech language pathologist, occupational therapist, audiologist, physical therapist, etc. for the problem?

9. Please describe your communication needs.

10. What do you hope to accomplish out of speech therapy?

11. Do you have any eating or swallowing difficulties? If so, explain:

Our Policies **Instructions: Please read the policies and *initial next to each statement.**

Patient Financial Responsibility
I agree to be responsible for all estimated deductibles, co-insurance, or co-payments. As in all health care situations, the guarantor is always responsible for payment. I understand that Central Coast Language and learning staff will contact my insurance carrier for estimated benefits and any requested payments will be the direct result of the verification. Therapy services may be put on hold or terminated if there is a problem regarding payment. _____

Change of Insurance
I agree to notify Central Coast Language and Learning Center within 5 business days of any change of insurance. Change of insurance does not guarantee coverage of therapy services and failure to provide accurate insurance information in a timely manner will result in the unpaid insurance balance being transferred to patient responsibility. _____

Cancellation Policy
Central Coast Language and Learning Center requires a 24-hour notice when you need to cancel an appointment. Any therapy session cancelled with less than 24 hours will be considered a "no show." If you fail to give this notice, we will charge you a missed appointment fee of $25. This charge is not covered by insurance and must be paid prior to the next scheduled appointment. Failure to make clear the missed appointment fee will result in the patient being put on hold. _____

Medi-Cal Cancellation Policy
Central Coast Language and Learning Center requires a 24-hour notice when you need to cancel an appointment. Any therapy session cancelled with less than 24 hours will be considered a "no show." We will charge you a missed appointment fee of $25. This charge is not covered by insurance and it must be paid prior to the next scheduled appointment. Failure to clear the missed appointment fee will result in the visits being placed on hold. _____

***In order for you or your child to make optimal progress, it is important to attend all scheduled therapy sessions. Excessive missed appointments, cancellations, or three "no shows" will result in immediate discontinuation of services. _____**

Sick Policy
The Board of Health considers the following signs to indicate communicable disease/illness: vomiting, fever over 100 degrees, diarrhea, sore throat, rash/swelling, red or running eyes. Please be sure you or your child is symptom free for 24 hours before resuming therapy. _____

Email & Text Policy
Central Coast Language and Learning Center will always communicate with you or your family in the most personally convenient way possible. Our office uses unencrypted email and text messaging to communicate about things such as appointments, schedules, or billing. Your private electronic health information will not be included in any email or text message. Please indicate your communication preferences below:

☐ Yes, please communicate with me via unencrypted email and text messaging.

☐ No, please do not communicate with me via unencrypted email and text messaging. I Understand that I will only be able to make and receive phone calls.

Name of person completing form	Signature	Date

HIPAA and Privacy Practices

HIPAA describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. For more information, visit Coastallearning.org.

I have received this notice of privacy practices and know where to go to get more information.

_____	_____	_____
Patient/Parent name	Signature	Date

Authorization for Release of Photographs, Video, Artwork, etc.

For use in marketing/communications; professional and community outreach

Please make a choice below:

☐ I hereby authorize Central Coast Language and Learning Center to use photographs of myself, my personal story and any related quotes for marketing materials (including, but not limited to, Facebook, CCLLC website, brochures)

☐ I hereby authorize Central Coast Language and Learning Center to use photographs of my child, his/her personal story and any related quotes for marketing materials (including, but not limited to, Facebook, CCLLC website, brochures)

OR

☐ Please do NOT use any photographs of myself or my child for marketing or community outreach.

THIS FORM HAS BEEN FULLY EXPLAINED TO ME AND I CERTIFY THAT I UNDERSTAND ITS CONTENTS AND ACCEPT ITS TERMS.

Signature: _____ Date: _____

If signing for a child, state your relationship to patient: _____