REDMOND
SPEECH & LANGUAGE
SERVING ALL OF CENTRAL OREGON

ADULT CASE HISTORY

MR#_____

Please complete the following form and bring it to your scheduled evaluation.

Name: _____ **Today's Date:** _____

Physician: _____ **Date of Birth:** _____

Address: _____ **Age:** _____

City/State/Zip: _____ **Phone Number:** _____

Email: _____**Cell/Work Number:** _____

Preference for Auto Reminders (circle one): email phone call text message

Reason/Person for Referral: _____

Background Information:
What are your current concerns regarding your speech, language, swallowing, or motor skills? _____

_____

What do you think caused the above difficulties? _____

_____

When was the problem first noticed and by whom? _____

Has the problem changed (worsened/ resolved) since it was first noticed? Describe. _____

_____

Have you ever seen a specialist/therapist regarding these difficulties? Who and when? What were their conclusions/recommendations? If so, do you have copies or may we obtain copies of progress and/or discharge reports?

_____

_____

_____

_____

_____

_____

Medical History:

Do you currently have any medical diagnoses? If so, what are they? _____

Have you ever had surgery or been hospitalized for any reason? If yes, please list and indicate approximate dates.

_____

Do you/ have you suffered from any illnesses or medical conditions? If yes, please list and indicate approximate dates.

_____

Are you currently taking any medications? Please list. _____

_____

Do you have any known allergies? (medications, foods, latex, seasonal, etc.) Please list. _____

_____

Has your hearing been evaluated? If so, indicate where, when, and the status of that evaluation.

_____

Has your vision ever been evaluated? If so, indicate when, where, and the status of that evaluation.

_____

Do you use English as a second language? If so, what is your native language? _____

Although an accent is not a disorder, do you find an accent is affecting your ability to communicate? Yes No

Family/ Social History:

Indicate current marital status: Single ___ Widowed ___ Divorced ___ Married ___

Spouse's Name if applicable: _____

List any children (names, gender, and ages): _____

Current or past occupation/employer: _____

Highest grade, diploma, or degree earned. _____

List who is currently living in your home and in what setting (i.e. 2-story house, 2nd floor apt, etc.): _____

_____

Is there any family history of speech, language, learning, hearing, medical or mental health issues? Yes No

Describe: _____

List hobbies/interests: _____

8. What is the best way you learn new things? ___Written instruction ___Demonstration ___Verbal instruction

___Hands-on learning ___Other: _____

Therapy History:

Have you ever received any type of therapy (speech/language, occupational, physical)? Yes No

Indicate which type(s) and durations: _____

Conditions treated: _____

Speech and Language Skills:

Do you have difficulty expressing your wants and needs? If yes, please explain. _____

_____

Do others find you difficult to understand? If yes, please explain. _____

_____

Do you find it hard to understand others? If yes, please explain. _____

_____

Do you have short-term and/or long term memory difficulties? If yes, please explain. _____

_____

Do you have difficulty with word-finding (i.e. remembering the names of objects and/or people)? If yes, explain.

_____

Do you have difficulty with reading or writing? If yes, please explain. _____

_____

Have there been any changes to your voice (i.e. hoarse, breathy, loss of volume)? If yes, please explain.

_____

Swallowing Skills:

Please indicate (check mark) if you have difficulty with any of the following:

- o Chewing Food
- o Drooling
- o Moving food to the back of the mouth
- o Managing Liquids
- o Increased meal times
- o Other _____
- o Watery eyes when eating/drinking
- o Coughing
- o Holding cup/utensils
- o Clearing food/ liquid from the mouth
- o Choking

Are you currently on a modified food and/or liquid diet? If yes, please explain. _____

_____

Are their food/liquid textures that you avoid? _____

Do you currently wear dentures? Indicate full or partial. _____

Activities of Daily Living:

Do you require assistance with any of the following?

- o Dressing
- o Toileting
- o Money Management/ Bill Payments
- o Cooking
- o Transportation/ Driving
- o Keeping track of appointments
- o Eating
- o Other _____
- o Showering/ Personal Hygiene
- o Moving/ walking from place to place
- o Telling Time
- o Making phone calls
- o Grocery Shopping
- o Housekeeping

Do you have any difficulties with fine motor skills to be able to manipulate clothing fasteners, utensils, opening jars, keyboarding, etc.? If yes, please explain. _____

_____

Therapy Goals:
What are your current speech/language therapy goals/expectations? _____

_____

Do you wish to proceed with private speech therapy if needed? _____

_____

What are your preferred/available times for therapy? _____

Are there any issues (language, religious, cultural, food restrictions, etc.) that may interfere with therapy?

_____

****Please provide any additional information that may be helpful to the evaluation/treatment process:**

_____

_____

_____

_____

Completed by _____ on _____ (date).

THANK YOU!

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NOTICE OF FINANCIAL RESPONSIBLITY

- **I hereby give Redmond Speech & Language: Total Communication Services, 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.**
  _____*initials*
- **I authorize payment of medical benefits to Redmond Speech & Language, LLC for all services.**
  _____*initials*
- **I authorize the release of any medical or other information necessary to process all claims. I also request payment of government benefits to Redmond Speech & Language, LLC.**
  _____*initials*
- **If payment is not issued by the insurance company within 90 days of initial filing, you are responsible for following up with insurance company and for payment of services.** _____*initials*
- **For patients with insurance coverage, co-payments are due at the time of service. Coinsurance and deductible amounts due when EOB statements are received.** _____*initials*
- **If your portion of payment is not made within 60 days, your appointments will be placed on "Hold" until the balance due is paid in full.** (See our policy for cancelations/missed appointments) _____*initials*
- **Clients with deductibles must pay the contracted rates that Redmond Speech & Language has with your insurance company.** It is illegal for us to offer a reduced or discounted rate when you have a set deductible / coinsurance. _____*initials*
- **For clients receiving speech/language therapy services there maybe multiple codes billed. Based on therapy modalities provided there maybe fluctuating charges.** _____*initials*
- **All Returned Checks will incur a $30 service fee.** _____*initial*
- It is your responsibility to inform the office as soon as possible if there is an insurance change and provide the office with the new insurance card. ***Failure to do this as soon as possible may result in the inability for us to obtain authorization for treatment, resulting in charges to your account at a regular rate.** _____*initials*
- Please inform the office of any foreseen cancellations within 24 hours of your appointment time. **All No-Show or Short Notice (less than 24 hour notice) appointments will incur a $30 fee/30 minute session or a $50 fee/50 minute session.** *Please note that insurance companies do not reimburse for these charges and they will be your responsibility. Three "no show" cancellations or habitual cancellations will result in the loss of a reserved treatment time slot and/or being discharged from therapy. ____*initials*

FINANCIAL RESPONSIBILITY

I have read the above and hereby accept all responsibility for the evaluation and treatment costs incurred by my child. The undersigned certifies that he/she has been provided the evaluation and treatment costs and is the responsible party and accepts these terms.

_____ _____

Responsible Party Signature Date

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CONSENT AND ACKNOWLEDGEMENT

Consent for Care and Treatment: As the client or legal representative of the client, I hereby consent to necessary evaluation, procedures and/or treatments prescribed by my child's speech language pathologist as is necessary in their judgment. I understand that my child is under the care and supervision of a speech language pathologist. I authorize release of medical information to the Redmond Speech & Language team for continuity of care.

_____ _____
Signature of Client/Legal Representative of Client Date

Acknowledgement of Notice of Privacy Practices: I acknowledge that Redmond Speech & Language: Total Communication Services, LLC will use and disclose my personal health information for treatment, payment, and other healthcare operations and as otherwise permitted by law. Our Notice of Privacy Practices provides further detailed information about how we use and/or disclose protected medical information about your child for treatment, payment, healthcare operations, and as otherwise allowed by law.

_____ _____
Signature of Client/Legal Representative of Client Date

PHOTOGRAPH AND VIDEO RELEASE FORM

I authorize Redmond Speech & Language: Total Communication Services, LLC to photograph me/my family member for use in the following categories. Parents or other clients may ask the names of clients in the pictures. I authorize that my first name may be mentioned when referring to these pictures.

I Give Redmond Speech & Language Permission to:	**Yes**	**No**
Take photographs or video for therapeutic purposes	_____	_____
Use photos for publicity purposes	_____	_____

_____ _____
Signature of Client/Legal Representative of Client Date

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Authorization for Release and Disclosure Of Protected Health Information

In accordance with state and regulatory agency requirements, the medical record is the property of Redmond Speech & Language: Total Communication Services, LLC

Patient Name: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____

I hereby authorize that my medical information be released to:
ALL MEDICAL SERVICES OR:

_____
_____

FROM:
Redmond Speech & Language: Total Communication Services, LLC
326 SW 7th St, Redmond OR 97756

Please release the following information:

___Initial Evaluation ___Re-evaluation ___Progress Notes ___Plan of Care

___History and Physical ___Discharge Summary ___Psychological Evaluation

___Other (Specify) _____

This information is necessary for the following purpose:

___ Continued Patient Care ___Insurance ___Personal Use ___Other (specify) _____

1. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing to Redmond Speech & Language. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

3. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, this authorization will expire after 60 days from signature date below.

4. I understand that authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Patient or Legal Representative Date

_____
Relationship to Patient