



REDMOND SPEECH & LANGUAGE

SERVING ALL OF CENTRAL OREGON

Dear New Patient,

Welcome to Redmond Speech & Language, where we provide total communication services.

At Redmond Speech & Language, our goal is to provide a wide range of evidence-based speech and language services to our community. We seek to collaborate with families and other professionals to effectively meet each patient's needs. We believe in each individual's right to communicate.

Our therapy staff are consummate professionals who are committed to mutually held values of integrity, service, professionalism, and research-based evaluation/treatment.

This New Patient Packet contains important information and forms necessary to complete prior to evaluation and treatment. Please take time to read all of the information carefully and feel free to ask any questions as you go through this process.

Communication therapy is a cooperative effort between our staff and you. Together we can make a difference in your communication or that of your family member.

Thank you for choosing Redmond Speech & Language: Total Communication Services, LLC.

Sincerely,

Angela Bacuyani, M.A. CCC-SLP & Christina Stevenson, M.S. CCC-SLP
Owners
Redmond Speech & Language: Total Communication Services, LLC



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GENERAL GUIDELINES

The following information is a list of general guidelines that will assist in creating a treatment environment that is as efficient and smooth as possible. If you have any questions, please speak with your therapist.

1. Individual treatment sessions are generally 30 or 50 minutes. The last 5-10 minutes of the treatment session may be used for family education, discussion and documentation. If you feel that you need additional time to discuss issues, please schedule that time with your therapist. This will prevent running into the next appointment.
2. You will be notified as far in advance as possible when your therapist is ill or otherwise unable to attend. Every effort will be made to shift to teletherapy, reschedule, or provide a substitute therapist for your appointments so that you will miss as little treatment as possible.
3. A patient may be sent home or shifted to teletherapy if they:
 - a. Appears ill and is unable to participate in therapy.
 - b. Is suspected of having a contagious disease/condition.
 - c. Sustains an injury which needs medical attention or close observation.
 - d. Exhibits vomiting and diarrhea.
 - e. Has a fever of 100 degrees or greater (a patient may not return to Redmond Speech & Language until they are fever free for 72 hours off of fever reducing medication).
4. To increase consistency and progress in the therapeutic setting, we have a text reminder system in place to remind families of their appointments and help our therapists plan for their sessions each day. You will receive several reminders between 72 hours and 2 hours prior to your appointment. Additional reminders can be added to accommodate multiple family members if needed. Please respond to each reminder as soon as possible. Contact your therapist or the front office directly for any rescheduling needs.



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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by Redmond Speech & Language: Total Communication Services, LLC. and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your health care bills, to support the operation of the Redmond Speech & Language's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your healthcare with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for the treatment.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of speech pathology students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your therapist. We may also call you by name in the waiting room when your therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization at any time in writing, except to the extent that your physician or the physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.



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ADULT CASE HISTORY

Name: _____ **Date of Birth:** _____ **Sex:** Male__ Female__ Other__

Gender ID (write): _____ **Preferred Pronouns (write):** _____

Address: _____

City/State: _____ **Zip:** _____

Email: _____ **Phone:** _____ **Phone Type:** _____

Occupation: _____ **Employer:** _____

Is patient the policyholder for insurance? **Yes** **No**

Preference for Auto Reminders: **email** **phone call** **text message**

Reason 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):

If you are retired, what was your occupation? What company did you work for?

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: _____

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:

Chewing Food

Drooling

Moving food to the back of the mouth

Managing Liquids

Increased meal times

Other _____

Watery eyes when eating/drinking

Coughing

Holding cup/utensils

Clearing food/ liquid from the mouth

Choking

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

Are there food/liquid textures that you avoid?

Do you currently wear dentures? Indicate full or partial.

Activities of Daily Living (ADLs):

Do you require assistance with any of the following?

Dressing

Toileting

Money Management/ Bill Payments

Cooking

Transportation/ Driving

Keeping track of appointments

Eating

Showering/ Personal Hygiene

Moving/ walking from place to place

Telling Time

Making phone calls

Grocery Shopping

Housekeeping

Any other ADLs to address? _____

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 _____ Date _____



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NOTICE OF FINANCIAL RESPONSIBILITY

FINANCIAL STATEMENTS	Initials
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.	
I authorize payment of medical benefits to Redmond Speech & Language, LLC for all services.	
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.	
If payment is not issued by the insurance company within 90 days of initial filing, I am responsible for following up with the insurance company and for payment of services.	
For each date of service, co-payments are due at the time of service.	
If my portion of payment is not made within 60 days, appointments will be placed on hold until the balance due is paid in full.	
The amount I owe is based on the contracted rates that Redmond Speech & Language has with my insurance company and cannot be negotiated.	
My appointment may include different types of speech/language therapy services and there may be multiple codes billed. Based on therapy modalities provided, there may be fluctuating charges.	
All returned checks will incur a \$30 service fee.	
It is my responsibility to inform Redmond Speech & Language 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 Redmond Speech & Language to obtain authorization for treatment from my insurance company, resulting in charges to your account at a self-pay rate.	

FINANCIAL RESPONSIBILITY

I have read the above and hereby accept all responsibility for the evaluation and treatment costs incurred. I certify that I am the responsible party and accept these terms.

Responsible Party Signature

Date



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ATTENDANCE POLICY - updated 4/15/2022

Our mission is to provide evidence based speech and language services to every patient we treat. After research and based on years of experience, it is evident to us that patients make the best progress when seen consistently. Cancellations interrupt the progress of therapy and reduce the effectiveness of treatment. For this reason, families are expected to make every effort possible to attend scheduled appointments. The following outlines our cancellation/rescheduling procedures. Please initial each line.

_____ **If I need to cancel I will call/text my therapist or the office ASAP.** Please give as much notice as possible if you need to cancel an appointment. We realize things happen last minute, but as soon as you are aware that you will need to miss an appointment, please notify us (even if after office hours).

_____ **If I cancel more than 1 time per month, I must reschedule a make-up visit that takes place within the following two weeks OR pay a \$50 cancellation fee*.** Regular attendance is necessary to make progress in therapy. When an appointment is rescheduled it is expected that I will attend that appointment in addition to my other scheduled appointments. Teletherapy is an option in most cases.

_____ **If I cancel an appointment for any reason within 48 hours, I must reschedule a make-up visit that takes place within the following two weeks OR pay a \$50 cancellation fee*.** When canceled with less than 48 hours notice, we are unable to fill that spot with another patient on the standby list.

_____ **If I do not show up for my appointment without canceling ahead of time, I must reschedule a make-up visit that takes place within the following two weeks AND pay a \$50 cancellation fee*.** As you may have guessed, communication is important to us. Just send a quick call or text.

_____ **Failure to reschedule/pay the fee as directed above will result in the loss of my set appointment time.** Should that happen I will be placed on a standby list and my appointments will be scheduled with any open therapist

_____ **If I am on a standby schedule there is no guarantee that I will see the same therapist** each visit or that a time slot will be available that works for my schedule.

_____ **If I am gone for more than two consecutive weeks, Redmond Speech cannot hold my time slot or customary therapist.** If you are out of town, teletherapy is an option in most cases.

_____ I understand that **my insurance will not pay for cancellation fees**, and if a cancellation fee is owed it must be paid **prior** to my next appointment. Payment links can be found at redmondspeech.com

***MEDICAID PATIENTS:** By law, we are prevented from charging attendance fees to medicaid patients. If your insurance provider is medicaid, you do not have the \$50 fee option. **Missed appointments must be rescheduled** and made up within two weeks. Failing this, you will be put on a standby list.

In signing this, I acknowledge that the above agreement and attendance policy was explained to me, and any questions regarding it have been answered. I also agree to follow the directions outlined in this policy.

Signature: _____

Patient Name: _____

Date: _____



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CONSENT AND ACKNOWLEDGEMENT

Consent for Care and Treatment: I hereby consent to necessary evaluations, procedures, and/or treatments prescribed by my speech language pathologist as is necessary in their judgment. I understand that I am 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 Patient/Legal Representative of Patient

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. I have received a Notice of Privacy Practices which provides further detailed information about how my protected medical information is used and/or disclosed for treatment, payment, healthcare operations, and as otherwise allowed by law.

Signature of Patient/Legal Representative of Patient

Date

PHOTOGRAPH/VIDEO/VOICE RECORDING RELEASE FORM

I authorize Redmond Speech & Language: Total Communication Services, LLC to use videos/photos/voice recordings of me for therapeutic purposes.

I Give Redmond Speech & Language Permission to:

Yes

No

Take photographs or video for therapeutic purposes

Signature of Patient/Legal Representative of Patient

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:

Name of Person/Organization	Address	Phone/Fax/Email

FROM:

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

Please release the following information: Initial Evaluation Re-evaluation Treatment Notes Discharge Summary

Other (Specify) _____

This information is necessary for the following purpose: Continued Patient Care Insurance

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. 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



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CREDIT CARD AUTHORIZATION

Redmond Speech & Language: Total Communication Services, LLC is requesting a credit card/debit card as a consistent form of payment, please fill out the section below. Thank you.

I authorize Redmond Speech & Language, LLC to keep my signature on file and to charge my account for balance of charges not paid by insurance within 60 days and not to exceed \$_____.

Circle one: American Express Visa MasterCard Discover Card

- _____ This visit only
- _____ All visits this year
- _____ Co-payments
- _____ No show or late cancellations charges
- _____ All visits from _____ to _____
- _____ Recurring charges of \$ _____

I understand this form is valid from the date that I sign until revoked in writing.

Patient's Name _____

Card Holder's Name _____

Cardholder's Signature _____

Card # _____

Expiration Date _____ CVC Code _____

Zip Code _____ Email Address (for receipt) _____