SPEECH & LANGUAGE CENTER
AT STONE OAK

Adult Case History

Last Name_____First_____MI____Date of Birth_____
Nickname or Preferred Name_____Age_____
Home Phone_____Cell_____Email_____
Address_____City_____State_____
Zip_____SSN#_____Drivers License#_____State_____
Primary Care Physician_____
Medical Diagnosis (if known)_____

Primary Insurance

Insured's Name_____DOB:_____

Insurance Co._____ ID#_____Group#_____

Secondary Insurance

Insured's Name_____DOB:_____

Insurance Co._____ ID#_____Group#_____

Employer_____Occupation_____Years Employed_____
Address_____City_____State_____

Marital Status: _____Single _____Divorced _____Married _____Widowed _____Separated

Spouse's Name_____Age_____
Employer_____Occupation_____
Children: _____None _____Small Children (Ages:_____) _____Adult Children

Emergency Contact
Last Name_____First_____Home Phone_____Cell_____
Relationship:_____

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How Did You Hear About Us?

___Doctor Referral (Name_____)
___Yellow Pages
___Friend
___Other Source (_____)

Medical Information

Please describe significant **childhood** illness/injuries/hospitalizations

Date:_____

Problem:_____

Outcome:_____

Date:_____

Problem:_____

Outcome:_____

Date:_____

Problem:_____

Please Describe significant **adult** illness/injuries/hospitalizations

Date:_____

Problem:_____

Outcome:_____

Date:_____

Problem:_____

Outcome:_____

Date:_____

Problem:_____

Outcome:_____

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Education

___High School Graduate ___G.E.D. ___Did not Graduate

___Associates Degree ___Bachelors ___Masters ___Doctorate

Degree in:_____Year_____

Degree in:_____Year_____

Other Information

Please check all that apply.

___Smoke ___Frequent Alcohol Use ___Occasional Alcohol Use ___Non Drinker

___Long Term Medications List:_____

___Exercise Regularly ___Do Not Exercise

___Engage in Hobbies List:_____

___Like to Read ___Like to Listen to Music ___Like to go to the Movies ___Like TV or Radio

I Find My Job: ___Very Stressful ___Moderately Stressful ___Seldom Stressful

I Am Satisfied with Myself: ___Most of the Time ___Some of the Time ___Dissatisfied

Reason for Referral:

_____

_____

_____

How Important is Your Speech to Your:

Job: ___Extremely ___Somewhat ___Not Important

Family: ___Extremely ___Somewhat ___Not Important

Ability to Communicate with Others: ___Extremely ___Somewhat ___Not Important

What are your main concerns about your speech?

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Nature of Problem:_____

When does it occur?_____

Nature of Problem:_____

When does it occur?_____

Are there any words you have difficulty with and wish to improve?

List: _____

Previous Treatment

Have you had prior treatment for your current problem? ___Yes ___No Date of Treatment_____

Name of Facility: _____

Results: ___Satisfied, but need more help ___Satisfied and felt treatment was completed ___Not Satisfied

What would you like to do that was not done before? _____

_____

_____

_____

What are your goals for speech treatment today? _____

_____

_____

_____

_____ _____

(Signature) (Date)

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Assignment of Benefits Form

Name of Insured (print): _____
(First) (Last) (Middle Initial)

Name of Patient (print): _____
(First) (Last) (Middle Initial)

Social Security (print): _____

Member/Subscriber ID _____

I request that payment of authorized insurance benefits, be made either to me or on my behalf to the organization listed below for any services provided to me by that organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related services to the organization, insurance carrier or other medical entity.

A copy of this authorization will be sent to my insurance company or other entity if requested. The original authorization will be kept on file by the organization.

I am financially responsible to the *Speech & Language Center at Stone Oak* for any and all charges not covered by health care benefits. I am responsible for the entire bill or balance for the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment.

I understand that by signing this form I am accepting financial responsibility as explained above for all payments for services received.

_____
Patient Signature / Parent's Signature if under 18 years of age

_____
Patient / Parent's Name (please print) Date

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Notice of Financial Responsibilities and Insurance Policies

Directions:
Please read and initial each section below.

_____I understand that I am financially responsible to the *Speech & Language Center at Stone Oak* for any and all charges not covered by my health care benefits at the time of service.

_____I understand that claims for my services may be subject to review by my insurance company *at any time* to determine medical necessity and any/or contract limitations that may exist according to my health plan and/or my insurance company.

> *The benefit information given to our Insurance Coordinator* ***is not a guarantee of coverage or payment.*** *In many cases, insurance benefits cannot be determined until the insurance company actually processes the claim. Although we typically file our claims within 24 hours, in most cases the insurance company can take up to 2-6 weeks, or longer, to process claims.*

_____I understand that this office expects payment from insurance companies within 15 business days, and that I may be billed for services not paid by my insurance company within 60 calendar days from the date of service.

> *Claims remain subject to retroactive insurance company review at any time. State regulated insurance policies currently limit review periods by law to 180 days from the date claim was received; however, federally regulated self-funded health plans have no time limits.*

_____I understand that in the event of retroactive review at any time for my claims as previously processed by my insurance company, I remain financially responsible for any and all charges deemed *not covered* by my health plan benefits on the date(s) of service.

_____In the event of adverse retroactive review, I understand that I may be billed for any and all charges determined as "not covered" and that I would remain financially responsible for these charges. Payment would then be due upon receipt of invoice sent by this business for these "non covered" charges.

_____I understand that while this office will exercise its best efforts, *as a courtesy,* to verify my health plan benefits and coverage, including any applicable authorizations, and tracking thereof, the policyholder and/or guarantor of the account remain responsible at all times for verifying coverage, obtaining/keeping up with current required authorizations, and seeking reauthorization for services as required/notified by his/her insurance company.

_____I understand that the policyholder and /or guarantor ultimately retains responsibility for ensuring accuracy of processed claims, verifying and/or obtaining any required authorizations, and tracking authorized visits as applicabl and/or required by my health plan. However, in most cases, this office, *as a courtesy,* will be able to obtain this information without difficulty.

_____I understand that I remain responsible for the entire bill or balance of the bill as determined by *Speech and Language Center at Stone Oak* and/or my health care insurance company if the submitted claims or any part of them are at any time denied for payment or deemed to be "non-covered" services.

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_____I understand that claims for services are filed for network insurance clients as a courtesy, and that the policyholder remains financially liable for any and all services not covered by his/her health plan at the time services are provided.

_____I understand that I am required to pay for all applicable copays, coninsurance, and/or deductibles for in-network health plans at the time of service.

_____I understand that I am expected to pay upfront for all applicable fees and charges for out-of-network health plans or private pay clients.

_____I understand that it is my responsibility to notify *Speech and Language Center at Stone Oak* of any changes to my health care coverage/plan in a timely manner.

If you have any questions about your financial responsibility or our Insurance Policies, please call us at

(210) 495-9944.

Patient's Signature (if over 18 years of age) Date

Circle all that apply:
Patient Parent Legal Guardian Policyholder Guarantor Other:_____

_____
Parent/Guardian's Name (please print)

_____
Parent/Guardian's Signature Date

_____
Relationship to Patient

I attest that the above individual was provided with the above financial responsibility information and this person's identity was verified by me, the undersigned:

_____
Office Staff Member Signature (SLCSO) Date

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New Patient Checklist

Patient Name: _____ **Date:** _____
Date of Birth: _____

_____ Parent Questionnaire
_____ Patient Information Sheet
_____ Assignment of Benefits Form
_____ Insurance Policy
_____ Notice of Privacy Practices
_____ Clinic Policies
_____ Clinic Cancellation Policy

I,_____, have received & understand *Speech & Language Center At Stone Oak's Clinic Policies*. I understand that missed appointments may be subject to missed appointment fees not to exceed the FULL COST of the appointment charge and/or loss of regular appointment time. I understand that make-ups are recommended for missed appointments, but that missed appointment fees may still apply.

I, _____, have received, and understand, the *Notice of Privacy Practices* and *Disclosures of Your Health Information*.

I, _____, have received, and understand, *Notice of Financial Responsibility and Insurance Policies*. I understand that I remain financially responsible to the *Speech & Language Center at Stone Oak* for any and all charges not covered by health care benefits at the time services are rendered. In many cases, insurance benefits cannot be determined until the insurance company actually processes the claim. Any charges determined by my insurance company to be "noncovered" expenses or charges will be due in full upon verbal or written notification by *Speech & Language Center at Stone Oak*.

I,_____, understand that my health plan benefits and coverage are a method of payment for costs of services according to my health plan's eligibility criteria and/or any applicable state mandates for group health insurance policies. I understand that the *Speech & Language Center at Stone Oak* expects prompt payment *within 15 business days* from insurance companies for in-network claims, which are typically filed electronically by this office within 1 business day from the date of service. I further understand that I, as the insured and/or guarantor, serve as the "Team Leader" for my insurance claims, and as such, I may be asked to contact my insurance company directly about any outstanding claims. I further understand that I may be subject to making payments directly to the *Speech & Language Center at Stone Oak* for any outstanding unpaid claims in excess of 60 calendar days.

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I, _____, by my signature below, hereby authorize the *Speech & Language Center at Stone Oak* to pursue any necessary action, including but not limited to: submitting written provider appeals, filing complaints to provider relations departments of insurance companies and/or any other appropriate regulatory entities, and/or any and all necessary legal recourse then available to providers in order to settle claim disputes.

_____ _____

Patient's Signature (if over 18 years of age) Name of Insured (please print)

_____ _____

Parent/Guardian's Name (please print) Name of Guarantor on Account (please print)

_____

Relationship to Patient

_____ _____

Parent/Guardian's Signature Date

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SPEECH & LANGUAGE CENTER
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CLINIC CANCELLATION & NO- SHOW POLICY

The Speech & Language Center at Stone Oak strives to offer clients the highest quality professional services available. An important part of the success of treatment sessions depends on consistency in attendance by patients. When we establish a plan of care, we base our goals on regular attendance. When appointments are missed, then progress may be impacted and treatment goals may not be achieved as quickly. Missed appointments are also costly to the therapists and this business, and regular attendance helps us keep our costs competitive. We expect that clients will take vacations, and certainly understand that sudden illness and events happen to all of us. In the event that you must cancel, we strongly encourage you to reschedule a make-up in order to maintain current progress.

NO CHARGES

1) Cancellation notice received by office staff (phone call, voice mail, email) ***by 5:00 pm CDT/CST day before*** scheduled appointment OR ***by 5:00 pm CDT/CST on federal holidays*** preceding date of appointment
2) First late cancellation within a six (6)month period (clients with 1x per week appointments)
3) First and second late cancellation six (6)month (clients with 2x or more per week appointments)
4) Professional staff has to cancel for any reason

Please note in the event of severe weather, we will follow the publicly posted closure policies of local school districts in the San Antonio metropolitan area. However, cancellation fees will be assessed if the schools and roads are open and weather is fair.

NOTE: Missed appointments remain subject to the ***Frequent Cancellation Policy*** *(see below).*

MISSED APPOINTMENT FEES (SPEECH):

SPEECH
$ 36 per missed appointment

MISSED APPOINTMENT FEES (READING / OTHER PROGRAMS):

READING / PREPAID READING / OTHER CLASSES
$ 36 per missed appointment

NOTE: Missed Appointment fees are NOT "Covered Medical Services" and will NOT be billed to insurance. Fees must be paid in full prior to next scheduled appointment.

LATE POLICY

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If you are late to an appointment up to 15 minutes, then we will conclude the session at the scheduled time and the therapist may elect to forego the conference time in lieu of providing direct treatment time. You will be charged and/or insurance will be billed for the full scheduled time.

If you are more than 15 minutes late to an appointment, then we may charge the missed appointment fee and reschedule the appointment.

NOTE: If your therapist is running late for any reason, you will be given your full session time, the option to be seen by another available therapist, or opportunity to reschedule your appointment. We regret any resulting inconvenience to your personal schedule.

FREQUENT CANCELLATION POLICY:

Clients may be removed from the regular appointment schedule at the sole discretion of the Business Office or Owner for any of the following reasons:

1) Two (2) consecutive late cancellations ***without*** rescheduling and keeping make-up appointments within two weeks of absence
2) Two (2) consecutive "no show" appointments (no noticed received by this office).
3) Frequent cancelled appointments regardless of reason.

HOW TO CANCEL:

Call ***or*** leave a voice message 24/7: (210) 495-9944.
Email cancellation to: Info@stoneoakspeech.com
Voicemail and email messages: Verified by business records.

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CLINIC CANCELLATION & NO- SHOW POLICY

We want to thank you for choosing our clinic to provide your therapy services. It is our goal to provide all clients with the highest quality professional services available.

I have read the attendance policy and understand the attendance expectations for me or my child.

_____ _____

Parent or Guarantor / Patient Date

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