SPEECH & LANGUAGE CENTER
AT STONE OAK

Patient Information Sheet

Patient's Name: _____DOB:_____
(Last) (First) (Middle)
Address: _____ _____ _____ _____
(City) (State) (Zip)
Home:( )_____Cell:( )_____E-mail_____

Primary Care Physician_____ Phone #( )_____

Primary Insurance

Insured's Name_____DOB:_____
Insurance Co._____ ID#_____Group#_____

Secondary Insurance
Insured's Name_____DOB:_____
Insurance Co._____ ID#_____Group#_____

Parent/ Guardian Information (If Applicable)

Mothers Name:_____DOB:_____
(Last) (First) (Middle)
Address: _____ _____ _____ _____
(If not the same as above) (City) (State) (Zip)
Home:( )_____Cell:( )_____E-mail_____
Occupation:_____Employer:_____Work#( )_____
Fathers Name: _____DOB:_____
(Last) (First) (Middle)
Address: _____ _____ _____ _____
(If not the same as above) (City) (State) (Zip)
Home:( )_____Cell:( )_____E-mail_____
Occupation:_____Employer:_____Work#( )_____

Emergency Contact

Name:_____Relationship_____
(Last) (First)
Home: ( )_____ Cell( )_____ Work( )_____

Payment

_____Yes, I understand that payment is due when services are rendered, and I agree to be responsible for payment

Name:_____ Date:_____

225 E. Sonterra Blvd, Suite 120
San Antonio, TX 78258
Phone: (210) 495-9944 | Fax: (210) 495-2540
www.stoneoakspeech.com

SPEECH & LANGUAGE CENTER
AT STONE OAK

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

225 E. Sonterra Blvd, Suite 120
San Antonio, TX 78258
Phone: (210) 495-9944 | Fax: (210) 495-2540
www.stoneoakspeech.com

SPEECH & LANGUAGE CENTER
AT STONE OAK

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 applicable 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.

225 E. Sonterra Blvd, Suite 120
San Antonio, TX 78258
Phone: (210) 495-9944 | Fax: (210) 495-2540
www.stoneoakspeech.com

SPEECH & LANGUAGE CENTER
AT STONE OAK

_____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.

_____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

225 E. Sonterra Blvd, Suite 120
San Antonio, TX 78258
Phone: (210) 495-9944 | Fax: (210) 495-2540
www.stoneoakspeech.com

SPEECH & LANGUAGE CENTER
AT STONE OAK

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.

225 E. Sonterra Blvd, Suite 120
San Antonio, TX 78258
Phone: (210) 495-9944 | Fax: (210) 495-2540
www.stoneoakspeech.com

SPEECH & LANGUAGE CENTER
AT STONE OAK

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

225 E. Sonterra Blvd, Suite 120
San Antonio, TX 78258
Phone: (210) 495-9944 | Fax: (210) 495-2540
www.stoneoakspeech.com

SPEECH & LANGUAGE CENTER
AT STONE OAK

CASE HISTORY- CHILD

Child's Name _____ Date of birth _____

Nickname or Preferred Name _____ Age _____ Grade _____

Address _____ Phone _____

City _____ State _____ Zip _____

Email contact :_____

Primary Care Physician _____

Medical Diagnosis (if known) _____

Family:

Father's Name _____ Age ____ Employer_____

Occupation_____

Mother's Name _____ Age ____ Employer_____

Occupation_____

Check All that Apply

Child lives with:

Both biological parents	___
Biological mother	___
Biological father	
Adoptive parents	___
Foster parent	___
Stepparent	___
Grandparent	___
Other	___

Languages Spoken at Home:

English only ___

English mostly (1 other language) ___

2 Languages (English+ _____ interchangeably) ___

No English at Home ___

Other children in the family:

Name	Age	Grade	Living in Home
_____	_____	_____	____Y ____N
_____	_____	_____	____Y ____N
_____	_____	_____	____Y ____N
_____	_____	_____	____Y ____N

225 E. Sonterra Blvd, Suite 120
San Antonio, TX 78258
Phone: (210) 495-9944 | Fax: (210) 495-2540
www.stoneoakspeech.com

SPEECH & LANGUAGE CENTER
AT STONE OAK

Child's Doctor(s):

Please list regular family physicians, pediatrician, and/or any specialists who may have seen your child within the past three (3) years or with whom you may have consulted regarding your child's problems.

Name	Address	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

Physical-Development History:

Prenatal:

Mother's age at the time of this pregnancy? _____ # Previous Pregnancies____

Any Medical problems before this pregnancy? Yes____ No____

Describe_____

Problems (mother) during pregnancy? Yes____ No____

Describe_____

Problems (baby) during pregnancy? Yes____ No____

Describe_____

Was pregnancy: Full Term_____ Premature____ Late____ Twin/Triplet/Quad/Other____

How many weeks_____ Early/Late

Birth:

Type of Delivery: Head first____ Feet first____ Other____ Required Forceps ____ Vacuum assist___

Spontaneous vaginal____ Planned C-section____ Unplanned C-section____

Duration of hard labor ____hours Medications at delivery (mother)_____

Birth weight ____pounds ____ounces Apgar Scores (if known) _____

Any problems (baby) at birth? Anoxia (blue) ____ Jaundice (yellow) ____Cleft palate ____

Cleft lip___ Respiratory distress_____ Sleepy____ Other____

Describe_____

Medications / Procedures required for baby at birth?

Describe_____

Additional hospitalization required (baby) at age weeks/months____ for days/weeks/months (duration)_____

Describe_____

225 E. Sonterra Blvd, Suite 120
San Antonio, TX 78258
Phone: (210) 495-9944 | Fax: (210) 495-2540
www.stoneoakspeech.com

SPEECH & LANGUAGE CENTER
AT STONE OAK

Infancy / Early Childhood:

Does or did your child do these things at an age appropriate level?

Held up head: Y___ N ___
Age at first word: Y___ N ___
Sat unsupported: Y___ N ___
Age at naming everything: Y___ N ___
Crawled: Y ___ N ___

Age at using 2-3 word sentence ____

Walked alone: Y ___ N ___
Used words: Y ___ N ___
Named everything: Y ___ N ___
Used short sentences: Y ___ N ___
Drank from cup: Y ___ N ___
Fed self with spoon: Y ___ N ___
Fed self with fork: Y ___ N ___
Toilet trained: Y ___ N ___
Day ___ Night ___

Does or did your child:

Play with sounds: Y ___ N ___
Babble: Y ___ N ___
Use Jargon: Y ___ N ___
Use varied sounds: Y ___ N ___
Use words: Y ___ N ___
Talk in short sentences: Y ___ N ___
Use full sentences: Y ___ N ___
Use clear sounds: Y ___ N ___
Use words correctly Y ___ N ___

Was or is your child fed by:

NG (nasogastric) tube Y ___ N ___ G tube Y___ N___ NPO at any time? Y___ N___

I/Family can understand my child:

___ most of the time ___ sometimes ___ very little

People outside the family can understand my child:

___ most of the time ___ sometimes ___ very little

225 E. Sonterra Blvd, Suite 120
San Antonio, TX 78258
Phone: (210) 495-9944 | Fax: (210) 495-2540
www.stoneoakspeech.com

SPEECH & LANGUAGE CENTER
AT STONE OAK

Medical / Dental / Feeding History:

Please mark Yes or No as appropriate (previous or current):

Y N

___ ___ ear infections
___ recurrent ___ chronic
___ isolated episode
___ ___ tubes placed in ears (age ____)
___ ___ fluid in ears
___ ___ frequent colds / sinus infections
___ ___ allergies (specify _____)
___ ___ food allergies (specify _____)
___ ___ hospitalizations (specify_____)
___ ___ surgeries (specify_____)
___ ___ high fever
___ ___ other illness (diabetes, eczema, etc.)
___ ___ asthma
___ ___ vision tested
___ ___ hearing tested ___newborn ___other
___ passed
___ failed ___hrng aids __unilat ___bilat
___ date tested
___ ___ difficulty socializing with peers
___ ___ difficulty socializing with adults
___ ___ unusual routines/preferences
___ ___ tonsils removed
___ ___ adenoids removed
___ ___ mouth breather
___ at rest
___ sleeping
___ ___ apnea
___ ___ ADHD / ADD
___ ___ takes medications for:_____
list meds:_____
___ ___ autism / Asperger syndrome

Y N

___ ___ reflux / GERD __infancy ___other ___
___ ___ problems w/ feeding ___infancy ___current
___ ___ eats baby food (please circle:
Stage I, Stage II, Stage III)
___ ___ eats most table foods
___ ___ likes only soft foods (pasta, chicken nuggets,etc)
___ ___ uses reg cup ___sippy cup ___straw
___ ___ gags easily
___ ___ coughs/ chokes while eating
___ ___ coughs/ chokes while drinking
___ ___ my child eats < 10 different foods
___ ___ eats meat/ chicken/ ground meat
___ ___ has diet restrictions (please specify _____)
___ ___ eats cooked vegetables
___ ___ eats raw vegetables
___ ___ eats fruit with peel
___ ___ frequently spits out foods_____
___ ___ current weight (age 3 or younger ____)
___ ___ current height (age 3 or younger ____)
___ ___ uses pacifier
___ ___ sucks thumb
___ ___ frequent rash near mouth
___ ___ tolerates teeth brushing (age 3 or younger)
___ ___ tolerates dental visits
___ ___ open bite / cross bite / lateral open bite
___ ___ tongue thrust
___ ___ orthodontia / other oral appliances
___ ___ sensory aversions (touch, sound, smell
other_____)
___ ___ Down syndrome
___ ___ other syndrome_____

Family Medical History:

Any history of significant medical, speech, language, psychological, and / or learning difficulties:

Family Medical History:

Father Yes___ No___ Age___ Problem(s) _____

Mother Yes___ No___ Age___ Problem(s) _____

Sibling Yes___ No___ Age___ Problem(s) _____

Other relative(s) _____

225 E. Sonterra Blvd, Suite 120
San Antonio, TX 78258
Phone: (210) 495-9944 | Fax: (210) 495-2540
www.stoneoakspeech.com

SPEECH & LANGUAGE CENTER
AT STONE OAK

School History:

Early childhood intervention program (ECI, Head Start, etc.) Y___ N___ Specify_____

Name of facility:_____ Year_____ City_____

Difficulty with: **Behavior** Y__N __ **Sensory** Y__ N__ **Feeding** Y__N__ **Speech** Y__ N__

Describe_____

Received OT___ PT___ Speech ___ Other_____

Nursery / Preschool Attended Y___ N___

School(s) attended: _____ Year_____ City_____

_____ Year _____ City_____

Performance in preschool as compared to same age peers:

Below average ____ Average____ Above average ____

Problems with: **Behavior** Y ___ N ___ **Attention** Y___ N___ **Learning** Y ___ N ___

Describe_____

Received OT___ PT___ Speech ___ PPCD___ Other _____

Kindergarten Attended Y___ N___

Age started kindergarten ____ Repeated kindergarten? Y ___ N___

School(s) attended: _____ Year _____ District_____ City_____

_____ Year_____ District_____ City_____

Performance in school: Below average ___ Average ___ Above average ___

Difficulty in kindergarten with learning Y ___N ___ **Speech** problems Y___ N___

Learning letters ___ Saying sounds of letters ___ Reading words ___ Other ___

Problems with: **Behavior** Y ___ N ___ **Attention** Y___ N___ **Learning** Y ___ N ___

Describe _____

Special education services ___OT ___PT ___Speech __ Resource___ PPCD___Other_____

225 E. Sonterra Blvd, Suite 120
San Antonio, TX 78258
Phone: (210) 495-9944 | Fax: (210) 495-2540
www.stoneoakspeech.com

SPEECH & LANGUAGE CENTER
AT STONE OAK

Elementary / Middle / High School

Repeated any grade(s)? Y___ N___ If Yes, which grade(s)_____

Performance in school: Below average ___ Average ___ Above average ___

Problems with: **Behavior** Y ___ N ___ **Attention** Y___ N___ **Learning** Y ___ N ___

Describe _____

Special education services OT___ PT___ Speech ___ Resource___ ALE___Other_____

Prior tutoring Y___ N___ (Specify_____)

Current School: _____ Grade: _____ District:_____

Performance in school: Below average ___ Average ___ Above average ___

Problems with: **Behavior** Y ___ N ___ **Attention** Y___ N___ **Learning** Y ___ N ___

Describe _____

Special education services ___OT ___PT ___Speech __ Resource___Other_____

(If in special education classes) Mainstreamed: All classes___ Other_____

Prior tutoring Y___ N___ (Specify_____)

Social:

Gets along most of the time with family members? Y___ N___ Peers? Y___ N___

Adapts to changes in family routine:

Extreme difficulty ___ Adapts with some difficulty ___ Adapts little or no difficulty ___

Plays regularly with at least one friend in age group Y___ N___

Tends to be: Leader ___ Follower ___ Plays by him/her self ___

Plays appropriately for his/her age Y___ N___ Uses pretend play Y___ N___

Follows rules most of the time:

At home Y___ N___ At school Y___ N___ Has trouble often ___

Social behavior compared with same age peers is:

Below Average ___ Average ___ Above Average ___

225 E. Sonterra Blvd, Suite 120
San Antonio, TX 78258
Phone: (210) 495-9944 | Fax: (210) 495-2540
www.stoneoakspeech.com

SPEECH & LANGUAGE CENTER
AT STONE OAK

Prior Treatment Services:

Has your child ever received treatment from:

Psychologist ___ Child Psychiatrist ___ Counselor ___ Family Therapist ___

Speech Therapist (or SLP) ___ OT ___ PT ___ Other ___ None___

Problem(s) _____

What is your primary concern today?

_____

_____

Previous Testing / Treatment for speech:

Name of facility / person providing treatment: _____

Purpose of treatment _____

Date(s) of treatment _____

Other facilities that have provided treatment _____ Dates _____ to _____

_____ Dates _____ to _____

_____

Signature of informant (indicate relationship to patient) / **Date Signed**

225 E. Sonterra Blvd, Suite 120
San Antonio, TX 78258
Phone: (210) 495-9944 | Fax: (210) 495-2540
www.stoneoakspeech.com

SPEECH & LANGUAGE CENTER
AT STONE OAK

Use / Consumption of Food Authorization

Patient's Name _____

I hereby authorize the use/consumption of the following foods for speech and oral motor therapy.

_____ All foods are ok to use

Please mark items that patient ***cannot*** have:

	Pixie Stix Candy (powdered candy)
	Flavor Spray (Citrus)
	Teddy Grahams
	Goldfish Crackers
	Gummy Lifesavers
	Bubblicious Gum
	Twizzler bites (licorice)
	Sour Candy Worms
	Smarties
	Lollipops
	Cheerios
	Cherry / Grape / Bubblegum flavored therapy items
	Pretzel Sticks
	Lemon / Lime juice

Please specify ***any*** food allergies:

_____

Parent / Guardian's Name (please print): _____

Relationship to patient: _____

Parent / Guardian's signature: _____ Date _____

225 E. Sonterra Blvd, Suite 120
San Antonio, TX 78258
Phone: (210) 495-9944 | Fax: (210) 495-2540
www.stoneoakspeech.com

SPEECH & LANGUAGE CENTER
AT STONE OAK

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.

225 E. Sonterra Blvd, Suite 120
San Antonio, TX 78258
Phone: (210) 495-9944 | Fax: (210) 495-2540
www.stoneoakspeech.com

SPEECH & LANGUAGE CENTER
AT STONE OAK

LATE POLICY

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.

225 E. Sonterra Blvd, Suite 120
San Antonio, TX 78258
Phone: (210) 495-9944 | Fax: (210) 495-2540
www.stoneoakspeech.com

SPEECH & LANGUAGE CENTER
AT STONE OAK

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

225 E. Sonterra Blvd, Suite 120
San Antonio, TX 78258
Phone: (210) 495-9944 | Fax: (210) 495-2540
www.stoneoakspeech.com

SPEECH & LANGUAGE CENTER
AT STONE OAK

PHOTO / AUDIO / VIDEO / DIGITAL IMAGE RELEASE

I hereby authorize Barbara A. Samfield, MA-CCC/SLP and /or Speech & Language Center at Stone Oak to use:

(Please initial by ALL images approved.) **Patient Name:_____**

____ My picture (print or digital) **Patient Age:_____**

____ My audio image including speech

____ My video image including speech

____ My written testimonial (part or whole as selected)

____ My written note to staff (professional or business, part or whole as selected)

My image may be used for:

(Please initial by ALL methods approved for use of my image.)

____ Baseline performance and progress records maintained in my digital patient file, which may be reviewed by Speech & Language Center Staff.

____ Reports sent to insurance companies, referring doctors, and/or referring professionals

____ Advertising purposes* (including posting on company website, Twitter, and/or Facebook)

**If my image is selected for advertising purposes, any identification of my image (if needed) would be restricted to use of patient's initials and age. Parent providing written testimonial would be referenced by relationship to patient. Example: Patient Mary Brown would be referenced as "M.B. (age 8)" / testimonial by Mother, M.B. (age 8).*

Limitations:

____ None

____ Specify:_____

This authorization shall remain in full force and effect for 2 year period from date signed.

_____ _____

Patient / Parent Signature (Required for minor under age 18) **Date Signed**

225 E. Sonterra Blvd, Suite 120
San Antonio, TX 78258
Phone: (210) 495-9944 | Fax: (210) 495-2540
www.stoneoakspeech.com