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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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 80% 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 7:00 pm CDT/CST day before scheduled appointment OR by 7:00 pm CDT/CST on federal holidays preceding date of appointment
2. First three (3) late cancellations within defined (6) month period* (clients with 1x per week appointments)
3. First six (6) late cancellations within defined (6) month period* (clients with 2x or more per week appointments)
4. Professional staff has to cancel for any reason

*Defined six (6) month period in this clinic are: January 1- June 30 and July 1-December 31
Also, any unused available waived LCA's do not accrue beyond the current six (6) month period.

Please note in the event of severe weather, we will follow the publicly posted closure policies of NEISD. 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 Frequent Cancellation Policy).

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.

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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.
4. Less than 80% overall attendance within each defined six (6) month period*

*Defined six (6) month periods in this clinic are: January 1 - June 30 and July 1 - December 31

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.

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

Patient Name	Parent or Guarantor/Patient Signature	Date

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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. Please sign below and return to office staff.

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

_____

Patient Name

_____ _____

Parent or Guarantor/Patient Signature Date

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