Communication 4 You, LLC
Laurel, MD
301-807-4821
princessevans1@verizon.net

SPEECH THERAPY
PATIENT REGISTRATION FORM

PATIENT INFORMATION DATE:

CHILD'S NAME: _____
LAST FIRST MI

DATE OF BIRTH: _____-_____-_____ SEX: M F

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

SCHOOL: _____ GRADE/CLASS: _____

TEACHER: _____

LANGUAGES: English (___%) ; _____ (___%) ; _____ (___%)

DIAGNOSIS:_____ PRECAUTIONS/CONTRAINDICATION FOR THERAPY_____

ANY KNOWN ALLERGIES, IE FOOD, LATEX…_____

HOW DID YOU HEAR ABOUT US? Dr._____Website_____Friend_____Phonebook._____Ad_____Other_____

PARENT/LEGAL GUARDIAN

NAME:_____SEX: (M F) MARITAL STATUS:_____
LAST FIRST MI

RELATION TO PATIENT:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

E-MAIL ADDRESS:_____ DO YOU CHECK THIS REGULARLY? YES NO

DAY PHONE: (____)_____EVE PHONE:(____)_____CELL PHONE:(____)_____

DRIVERS LICENSE: _____ STATE: _____ DATE OF BIRTH: _____- _____ - _____

EMPLOYER_____ BUSINESS ADDRESS_____

NAME:_____SEX (M F) MARITAL STATUS:_____
LAST FIRST MI

RELATION TO PATIENT:_____

ADDRESS: _____CITY:_____STATE:_____ZIP:_____

E-MAIL ADDRESS:_____ DO YOU CHECK THIS REGULARLY? YES NO

DAY PHONE:(____)_____EVE PHONE:(____)_____CELL PHONE:(___)_____

DRIVERS LICENSE: _____ STATE: _____ DATE OF BIRTH: _____- _____ - _____

EMPLOYER_____ BUSINESS ADDRESS_____

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PATIENT'S PRIMARY PHYSICIAN

PHYSICIAN NAME_____

PRACTICE NAME:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

PHONE: (_____)_____FAX: (_____)_____

PRIMARY INSURANCE

PRIMARY INSURANCE POLICYHOLDER: _____

RELATION TO PATIENT: _____ BIRTHDATE: _____ - _____ - _____ DRIVERS LIC. #:_____

INSURANCE COMPANY: _____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

PHONE: (_____)_____FAX: (_____)_____

SUBSCRIBER I.D. #: _____ GROUP #: _____

ACKNOWLEDGEMENTS

HIPAA: Notice of Privacy Practice

By signing this statement you are acknowledging that you have had the opportunity to receive Communication 4 You, LLC HIPAA Notice of Privacy Practices:

PATIENT NAME
(printed):_____

Signature:_____Date:_____

Parent/Legal Guardian or self

INSURANCE CERTIFICATION AND RELEASE AUTHORIZATION

This is to certify that I, _____ authorize Communication 4 You, LLC to apply for benefits for services rendered to me or my child by speech pathologists. If payment is not made to Communication 4 You, LLC for any reason, I _____ understand and agree that I am responsible for payment in full for any/all services that I have received from Communication 4 You, LLC. whether or not such services are covered by insurance benefits. I agree to reimburse Communication 4 You, LLC for any expenses, including reasonable attorney's fee, incurred in connection with the collection of sums due for services provided.

I further certify that the information I have provided concerning my insurance coverage is correct. I also realize that confirming coverage of insurance benefits is a courtesy done on my behalf by Communication 4 You, LLC. I understand and agree that I am ultimately responsible for checking with my insurance company/carrier as a follow-up, and that failure to do so may result in a lesser payment or no payment at
all.

I understand and agree that any and all referral documentation and or information, if required by my insurance carrier, is MY RESPONSIBILITY to obtain and provide to Communication 4 You, LLC by no later than the date of my appointment.

I further authorize Communication 4 You, LLC to release any information, including medical information for this or any related claims to any insurance company or reimbursing agency in order to determine benefits to which I may be entitled.

I have read, understand, and agree to the above:

_____

Signature of Responsible Party

If the patient is under the age of 18, please complete the following:

The undersigned is a parent/guardian of the patient and executes this form on their behalf:

_____ Signature
of parent/guardian

_____
Please print name and relationship to patient

Date form completed: _____

PATIENT FINANCIAL AGREEMENT

We are pleased you have chosen Communication 4 You, LLC. for your speech therapy care. We are dedicated to providing our patients with the best possible care and service, while keeping the costs to you from increasing. We do not render service in order to collect money, but we must collect in order to render service. We ask your help by understanding and cooperating with our financial policy.

We believe that our Patient Financial Agreement is as important as the services that we perform. It is our responsibility to inform you of charges and our payment guidelines prior to treatment. Determining costs for insured patients is more difficult and less accurate. Your insurance is a contract between your employer and an insurance company. Benefits received are based on the terms of the contract negotiated between your employer and the insurance company, and not Communication 4 You LLC. The goal of insurance policies is to provide basic care and many needed services may not be covered. Our office will do everything possible to help you understand and make the most of your insurance benefits. As a courtesy, our office will complete and submit your insurance forms to achieve the maximum reimbursement to which you are entitled. Please remember that you are ultimately responsible for all expenses incurred. We urge you to read your insurance policy so that you are fully aware of coverage and any limitations of the benefits provided. We will gladly discuss our payment options with you before beginning your treatment.

Insurance:
We participate with certain insurance plans. It is your responsibility to provide us with your correct and current insurance information at the time of your visit and to make sure that we are providers with your specific plan. If you fail to present the correct and current insurance information at the time of your visit, then you agree to be responsible for 100% of our usual and customary charges for your visit.

If we participate with your plan, we will provide the service if filing a claim to your insurance company for office charges, unless we have received prior notification of non-covered services. Those services, along with all co-pays and deductibles are the patient's responsibility and must be paid at the time of your visit. Any fees not billable to insurance will be disclosed in advance, and you will be required to sign a waiver acknowledging our policy before services will be rendered. In addition, you will be given the necessary paperwork to file to your insurance company.

We will file the initial claim to your insurance company. Our office policy is to allow for one subsequent filing. If, after the second filing the claim remains unpaid, then the balance will be transferred to your responsibility and payment will be expected upon receipt of a statement. We will work with you to ensure that our services have been billed correctly, the ultimate responsibility for the timely payment for services rendered is yours. If you are owed a refund, the refund will only be issued when your account balance is zero.

If we do not participate with your insurance, payment in full will be due at the time of your visit.

Payment for services performed:
Our office accepts cash, personal checks, Visa, MasterCard, and Discover. There is a $25.00 fee for co-pays not paid at the time of service, and a $40.00 charge for returned checks. Any patients requiring correspondence via certified mail will be charged a $20.00 fee. All outstanding balances are due within thirty (30) days, unless prior arrangements are made with the billing office. All past due balances are assessed a finance charge of $25.00 per month after sixty (60) days. All balances over 90 days will be sent to a collection agency. You will be financially responsible for all collection and legal fees incurred by Communication 4 You LLC in the collection of your delinquent balance.

Broken Appointment Policy:
The time for your child's appointment has been exclusively reserved for you and your child. We require that at least 4 hours notice be given, as a courtesy to us and to other patients. **THE BROKEN APPOINTMENT FEE**

WILL BE $50, UNLESS OTHERWISE NOTED. Therapy must be consistent in order to be beneficial and frequent cancellations may result in the loss of your child's regularly scheduled appointment time.

The patient and/or responsible party has received, read and understand the financial agreement and broken appointment policies. The patient and /or responsible party listed below hereby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with whom this office has a contracted agreement, the patient and /or responsible party agree to pay all applicable co-payments, and deductibles which arise during the course of treatment for the patient. The patient and/or responsible party also agree to pay for treatment rendered to the patient which is not considered to be covered by insurance.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY SET FORTH BY CSTC THERAPIES INC AND AGREE TO THE TERMS. I ALSO UNDERSTAND THAT THE TERMS OF THIS POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

I have read the above policy and agree to abide by it.

_____ _____

Signature Date

I agree that I am responsible for immediate payment of any balances over 90 days and that I will be responsible for obtaining insurance reimbursement for any outstanding claims.

Child(ren)'s name: _____

Name of parent/guardian: _____

Signature: _____ Date: _____

MEDICAL HISTORY:	YES	NO
Was mother's condition during pregnancy good to excellent?	____	____
Were medications taken during pregnancy? If yes, what?	____	____
Were there any complications/illnesses during pregnancy? What?	____	____
Was your baby born within two weeks of due date?	____	____
Was your child adopted?	____	____
Were labor and delivery normal?	____	____
Was labor induced?	____	____
Was there evidence of injury or poor health at birth?	____	____
During the first month of life, was child's health good?	____	____
Were there any feeding problems as a baby or toddler?	____	____
Was your child's activity level average as a baby and toddler?	____	____
Does your child have allergies or are allergies suspected?	____	____
Was development of teeth normal?	____	____

**Please comment on any of the above areas that were unusual:

_____

_____

Has your child had ear infections? List frequency and severity. Were antibiotics effective in treating the problem?_____

Has your child had hearing testing or tympanometric testing? When and where? Does your child have tubes in his ears? Do you have any concerns about his hearing?

_____

List any additional illnesses, injuries and hospitalizations your child has had, including severity of illness and frequency. List any medications that are taken regularly.

_____

_____

DEVELOPMENTAL HISTORY:

Does your child exhibit or has he exhibited any of the following behaviors? If so, please indicate age and any attempts to alter his behavior.

Behavior	Age	Comments
Excessive Shyness	_____	_____
Thumb /Pacifier Sucking	_____	_____
Difficulty separating from parents	_____	_____

Temper Tantrums _____ _____

Sleep Difficulties _____ _____

Difficulty Staying Still _____ _____

Attention Problems _____ _____

Does your child play well with other children? Do you have any concerns about your child's play?

_____

_____

Does your child have any academic difficulties?_____

_____

When did your child first achieve the following motor milestones? Please comment on difficulties or concerns.

Milestone	*Age*	*Comments*
Crawling	_____	_____
Sitting Unassisted	_____	_____
Walking	_____	_____
Holding a Cup	_____	_____
Using a Spoon	_____	_____
Using Crayons	_____	_____
Toilet Training	_____	_____

When did your child first exhibit the following speech/language skills?

Milestone	*Age*	*Comments*
Babbling	_____	_____
Imitating Words	_____	_____
Using first word meaningfully	_____	_____
Putting words together	_____	_____

Did your child's speech/language development seem to develop normally and then stop or regress?

_____

Does (s)he understand what is said to her?

_____

Does (s)he follow spoken directions?

_____

Does (s)he talk in (check one) single words ____; phrases ____; complete but grammatically incorrect sentences ____; complete grammatically correct sentences ____.

Does (s)he retell stories or experiences that can be understood? _____

Does (s)he often hesitate and/or repeat sounds and words? _____

Is his/her speech (check one) too fast _____, too slow _____, average _____ ?

Is his/her voice (check) too soft _____, too loud _____, average loudness _____, hoarse _____, nasal _____, denasal (stuffed as during a cold) _____, other _____ ?

FAMILY HISTORY:

Names of Siblings	Birth Dates
_____	_____
_____	_____
_____	_____

Others in the Home _____

Have any other family members or relatives had the following difficulties?

Difficulty	*Yes/No*	*Relationship to Child*
Speech or Language Problem	_____	_____
Hearing Problem	_____	_____
Learning Disability	_____	_____
Reading Problem	_____	_____
Emotional Problems	_____	_____
Other	_____	_____

PRIOR EVALUATIONS/THERAPY:

Has your child been seen by any other specialists? Yes ____ No _____

Please list any specialists your child has seen for medical, developmental, or educational concerns. Please list current therapists, if any.

_____
_____
_____
_____

Please add any additional comments or information that we may need to know in order to better serve your child. Thank you.

_____
_____
_____
_____
_____

**Please return this form along with copies of any previous evaluations, educational plans or other reports you would like us to consider when assessing or treating your child.