harbor speech PATHOLOGY
hope, healing and recovery

Adult Admission Form

TODAY'S DATE: _____

PATIENT INFORMATION:

Social Security Number: _____ Sex: ❑ Male ❑ Female

Patient Name:_____ Date of Birth: _____

Street Address: _____

City_____State _____ Zip: _____

Home Phone Number: _____ Other/Cell Phone: _____

Reminder Call Preference: ❑ Home Phone ❑ Cell Phone

E-Mail Address: _____Marital Status: ❑ Single - ❑ Married - ❑ Separated - ❑ Divorced - ❑ Widowed _____

Employment Status: ❑ Full Time - ❑ Part Time - ❑ Not Employed - ❑ Retired

Employer: _____ Phone Number: _____

Parent/Guardian (if under 18): _____

Next of Kin Not Living With You:_____Phone:_____

Street Address: _____

City_____State _____ Zip: _____

Referring Physician/Primary Care: _____

Insurance Information: PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD/CARDS

Primary Insurance: _____ **Phone:** _____

ID Number: _____**Group Number**: _____

Subscriber Name: _____**Date of Birth**: _____

Relationship to Patient: ❑ Self - ❑ Spouse - ❑ Child SSN:_____

Secondary Insurance: _____ **Phone:** _____

ID Number: _____**Group Number:** _____

Subscriber Name: _____**Date of Birth:** _____

Relationship to Patient: ❑ Self - ❑ Spouse - ❑ Child

Release of benefits and information: I hereby authorize my insurance benefits be paid directly to the practitioner. I am financially responsible for any balance due. I authorize the practitioner or insurance company to release any information required for any claims. I understand that simple interest will be added to any unpaid balance after 60 days of 1.3%.

Signature of patient or responsible party_____

Date:_____Relationship to Patient:_____

To Be Completed by Speech-Language Pathologist:

ICD-10: _____**CPT:**_____

harbor speech
PATHOLOGY

hope, healing and recovery

Welcome to Harbor Speech Pathology! We are happy to assist you with any questions you may have. Please take a few moments to read the following information.

Insurance: We accept most major insurance plans. As a courtesy to you, we will call your insurance company to verify your coverage for therapy in our office. Benefits quoted by an insurance representative are not a guarantee of payment and at times, can be quoted incorrectly. We encourage you to call your insurance company prior to your first appointment to verify that you are covered for therapy in our office.

Evaluation: Depending on age and abilities, we spend between 30 minutes and 1 hour with patients for the first appointment to determine the treatment plan and present levels of functioning. The evaluation generally involves a detailed intake, a speech and language, cognitive, voice or swallow assessment, goals and objectives to target if needed. Please understand that the unpaid balance is your responsibility.

Treatment: We are able to accommodate our patients with appointments times from 9:00 a.m. to 5:00 p.m., Monday through Thursday. We do our best to find a regular appointment time (weekly or bi-weekly, if desired) for each patient with one of our therapists.

Cost of Supplies: Occasionally, with your consent, we will order supplies to be used in your therapy sessions and at home. In the case that your insurance company does not cover these expenses, you will be responsible for the bill.

Financial Policy: Insurance co-pays are due at time of service. It is the policy of our office to bill all claims to your insurance company as a courtesy to you. The responsibility for payment of your account remains with you at all times, including closed or rejected Labor and Industries claims.

Your insurance policy is a contract between you and the insurance company. In many instances your insurance will cover only a portion of the charges. You should be aware that you are responsible for the balance of your bill. If your claim is denied, you will be responsible for the entire charge. If no insurance is available, private payment is due at the time of service. We accept personal checks, all major credit cards, and cash payments.

Referrals/Prescriptions: It is Harbor Speech Pathology's policy to have a referral or prescription on file for all patients, regardless of your insurance company's requirements. It is your responsibility to obtain one from your primary care physician and make sure we have it at the time of service.

I HEREBY AGREE TO FULL RESPONSIBILITY FOR ALL EXPENSES INCURRED BY OR IN THE ACCOUNT OF _____.

I AUTHORIZE MY INSURANCE COMPANY TO PAY DIRECTLY TO HARBOR SPEECH PATHOLOGY FOR SERVICES RENDERED. I AGREE THAT I WILL PAY ANY REMAINING BALANCE NO LATER THAN 30 DAYS FOLLOWING THE INSURANCE PAYMENT.

_____ _____

Signature of patient or authorized representative Date

5202 Olympic Drive NW, Suite 100 Gig Harbor, WA 98335 P (253) 851- 0007 F (253) 514-8261
1230 Bay Street, Suite 100 Port Orchard, WA 98366 P (360) 876-1717 F (253) 514-8261
info@harborspeech.com I harborspeech.com

harbor speech
PATHOLOGY
hope, healing and recovery

Cancellation Policy

Dear Valued Patient,

We realize that coming to us for treatment requires a substantial investment in time on your part. We have adequate staff on hand to allow 30-60 minutes for each appointment. This does mean that if you cancel an appointment without adequate notice, we may not be able to fill your appointment time. If you arrive late for your appointment you will miss part of your treatment for that day.

We charge a fee of **$50.00** if an appointment is canceled without 24-hour notice. This charge is NOT covered by insurance and will be your direct responsibility. This is much less than the value of an appointment. It is not intended to be punitive but rather to offset part the cost of having a therapist scheduled.

Thank you for your understanding with this policy as we provide you with quality services.

Sincerely,

Channa Beckman, M.A., CCC-SLP / CBIS
Harbor Speech Pathology

I have read and understand Harbor Speech Pathology's cancellation policy.

_____ _____

Signature Date

5202 Olympic Drive NW, Suite 100 Gig Harbor, WA 98335 P (253) 851- 0007 F (253) 514-8261
1230 Bay Street, Suite 100 Port Orchard, WA 98366 P (360) 876-1717 F (253) 514-8261
info@harborspeech.com I harborspeech.com

harbor speech
PATHOLOGY
hope, healing and recovery

CONSENT FOR DISCLOSURE
WRITTEN AND VERBAL COMMUNICATIONS

I, _____, hereby authorize and request Harbor Speech Pathology or its representatives to:

( ) Release information to ( ) Obtain information from ( ) Exchange information with the following individual(s):

_____

_____

_____

_____

Regarding: _____ Date of Birth: _____

INFORMATION TO BE RELEASED:	YES	NO
Progress reports	_____	_____
Evaluations of treatment participation	_____	_____
Medical history/Social history	_____	_____
Alcohol and other drug history	_____	_____
Psychological/Psychiatric testing, evaluation and reports	_____	_____
Other (specify) _____	_____	_____

_____

I understand that my records are protected under the Federal (42CFR) and State (RCW 71.05.390) confidentiality Law and Regulations. I also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it, and that, in any event, this consent expires automatically as specified below or in 90 days without such specification. This information released may be obtained via mail, telephone, fax, or in person.

Specification of the date, event, or condition upon which this consent expires: _____

_____ _____
PATIENT/ GUARDIAN /SIGNIFICANT DATE

_____ _____
WITNESS DATE

5202 Olympic Drive NW, Suite 100 Gig Harbor, WA 98335 P (253) 851- 0007 F (253) 514-8261
1230 Bay Street, Suite 100 Port Orchard, WA 98366 P (360) 876-1717 F (253) 514-8261
info@harborspeech.com I harborspeech.com