harbor speech PATHOLOGY
hope, healing and recovery

# Harbor Speech Pathology Admission Form

**Date:** _____

Diagnosis Codes: _____ Treatment Codes: _____
Please fill out ALL spaces below to the best of your knowledge—Thank you

## PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ E-Mail Address: _____

Street Address: _____ City, State, Zip: _____

Home Phone Number: _____ Other/Cell Phone: _____

Parent/Guardian (if under 18): _____

Emergency Contact Name: _____ Phone Number: _____

Which Physician referred you to us? _____

Who is your Primary Care Physician? _____

How did you hear about our clinic? _____

## INSURANCE INFORMATION

Primary Insurance: _____ Phone: _____

Subscriber Name: _____ Date of Birth: _____

ID Number: _____ Group Number: _____

Secondary Insurance: _____ Phone: _____

Subscriber Name: _____ Date of Birth: _____

ID Number: _____ Group Number: _____

## AUTO, L&I, WORKERS COMPENSATION PATIENTS ONLY:

Insurance Company: _____ Date of Injury: _____

Claim Manager Name: _____ Phone Number: _____

Address: _____

Claim Number: _____

What are we seeing you for today? _____

Onset: _____

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.

**Consultation:** We are happy to talk with prospective patients for a fifteen-minute consultation to answer any questions the patient or their guardian may have.

**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. The evaluation generally involves formal and informal testing as well as time for your therapist to get to know you and your unique situation. Most insurance companies cover the cost of a speech evaluation regardless of if they cover the subsequent therapy visits. Occasionally, there are co-pays or uncovered portions of an appointment. Please understand that any unpaid balance is your responsibility.

**Treatment:** We are able to accommodate our patients with appointments times from 9:00 a.m. to 6:00 p.m., Monday through Friday. We do our best to find a regular appointment time (weekly or bi-weekly, if desired) for each patient with one of our four Speech-Language Pathologists.

**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:** Some insurance companies and insurance plans require a referral for Speech Therapy. If your insurance requires a referral/prescription, it is your responsibility to obtain one from your primary care physician and to make sure that we have it at the time of services.

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

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# 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 cancelled without 24-hour notice.**
This charge is **NOT** covered by insurance and will be your direct responsibility.
This is much  than the value of an  appointment. It is not intended to be punitive but rather to partly offset the cost of paying the staff on hand for the time set aside for you.

Thank you for your understanding with our policy as we do our best to provide you with quality service.

Sincerely,

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

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

_____
**Printed Name**

_____ _____
**Signature** **Date**

# 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