Integrity REHAB

Adult Registration Packet
Speech Language Pathology

Scan No. _____

Initials _____

PATIENT INFORMATION

Patient Name (Last, First, Middle Initial)		Marital Status: M S W D Circle One: Female or Male	
Address		Social Security Number	Date of Birth
City	State Zip Code	Email Address	
Best Contact Number	Emergency Contact Name/Number		

What type of appointment reminder do you prefer? □ Email □ Phone call

What format do you prefer for your rehab documents and home exercise program? □ Email □ Printed handouts

Are you receiving any nursing, aide, or therapy services in your home? □ Yes □ No *(If yes, notify the Front Office)*

For Medicare beneficiaries, have you received therapy in this calendar year? □ Yes □ No

Is this a Workers' Comp injury? □ Yes □ No **Date of Injury:** _____ **Adjustor:** _____ **Employer:** _____

INSURANCE INFORMATION

Primary:	**Secondary:**	**Tertiary:**
Policy/ID#:	**Policy/ID#:**	**Policy/ID#:**
Name of Policy Holder:	**Name of Policy Holder:**	**Name of Policy Holder:**
Relationship to Patient:	Relationship to Patient:	Relationship to Patient:
Date of Birth (Policy Holder):	Date of Birth (Policy Holder):	Date of Birth (Policy Holder):
SS# of Insured (Policy Holder):	SS# of Insured (Policy Holder):	SS# of Insured (Policy Holder):
Effective Date:	Effective Date:	Effective Date:
Group Number:	Group Number:	Group Number:

This is an estimation of benefits. It may change based on your insurance.

YTD Deductible $:	YTD Deductible $:	YTD Deductible $:
YTD Deductible Met $:	YTD Deductible Met $:	YTD Deductible Met $:
Co-Pay Per Visit $:	Co-Pay Per Visit $:	Co-Pay Per Visit $:
Estimated Co-Insurance Per Visit $:	Estimated Co-Insurance Per Visit $:	Estimated Co-Insurance Per Visit $:
Insurance Coverage %:	Insurance Coverage %:	Insurance Coverage %:
Patient's %:	Patient's %:	Patient's %:
Total Visits Authorized: Visits Available: Auth End Date _____ $ Limit_____ **Are we in network? □ Yes □ No**	Total Visits Authorized: Visits Available: Auth End Date _____ $ Limit_____ **Are we in network? □ Yes □ No**	Total Visits Authorized: Visits Available: Auth End Date _____ $ Limit_____ **Are we in network? □ Yes □ No**

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Adult Language & Medical History (1)

Patient Name: _____

Date of Birth: _____

Name of your Primary Care Physician: _____ **Location:** _____

What is the highest grade, diploma, or degree you earned? _____

Check reason/s seeking therapy services:

1) _____Hearing 2) ____Speech 3) _____Swallowing 4) _____Other:_____

Please explain the problem more and tell when you first noticed the problem. Did it occur suddenly or gradually?

_____

What do you think may have caused the problem and has it changed in the past year?

_____

Please describe any hearing, speech, swallowing problems in your family: _____

_____

Please list specialist/s seen (ENT Physician, Neurologist, Psychologist/Psychiatrist, Speech-Language Pathologist)

DATE	LOCATION	SPECIALIST	RESULTS

Check current symptoms and chronic conditions you are experiencing or have experienced:

___Allergies
___Asthma
___Cancer
___Chronic Cough
___Difficulty getting volume
___Dry Mouth
___Dry Throat
___Feeling a "lump" in throat
___Fatigue after speaking
___Frequent Bronchitis
___Frequent Laryngitis
___Frequent Sore Throat
___Frequent Throat Clearing
___Gastrointestinal Problem
___Hearing Loss
___Heartburn/Gastro-Esophageal Reflux
___Heart Problems
___Hiatal Hernia
___High Blood Pressure
___Low Blood Pressure
___Loss of Voice in morning
___Loss of Voice at night
___Shortness of Breath
___Stomach Ulcers
___Stroke
___Throat Tightness
___TMJ

OTHER (Please specify) _____

Please list any hospitalizations, injuries, surgeries, and other conditions you have had:

DATE	INJURIES/SURGERIES/OTHER	REASON

Please list all PRESCRIPTION (Rx) and OVER-THE-COUNTER (OTC) medications you are currently taking (Include all injectable, oral, rectal, and topical medications):

_____

_____

Please check frequency of pain interfering with activity and movement:

____ 0=No pain ____ 1 = Less often than daily ____ 2 = Daily but not constantly ____ 3 = All the time

Check the way you best learn. ___Listening ____Performing the task ____Watching

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Adult Language & Medical History (2)

Patient Name: _____
Date of Birth: _____

Speech History: Problem? _____YES _____NO
Please describe your problem with speech_____
Please check all that apply:
_____ Hoarse _____ Whispery/Breathy _____ Quieter _____ Other _____
What was the date of onset of your voice/speech change? _____
Has your voice/speech changed in the past year? _____YES _____NO
Are you a singer? _____YES _____NO
Have you received formal voice training in the past? _____YES _____NO

Auditory (Hearing) History: Problem? _____YES _____NO
Please describe your loss/problem with hearing_____
When did you first notice this problem? _____
Which ear is affected? _____Right _____Left _____Both
What do you think caused your hearing loss/problem? _____
Do you ever experience dizziness, balance problems, or spinning sensation? _____YES _____NO
If YES, please describe _____

Dysphagia (Swallowing) Case History: Problem? ____YES _____ NO
Describe your problem with swallowing_____
When did you first notice this problem? _____
Please check if your swallowing problem is: _____Intermittent or _____ Constant
Has your swallowing problem changed over time? ____YES ____NO **Describe:** _____
Please list any factors that make your swallowing problem worse _____
Please check if you have experienced or are experiencing any of the following:
_____ Avoid certain food due to difficulty in swallowing. **Describe:** _____
_____ Certain positions make it more difficult to swallow. **Describe:** _____
_____ Difficulty keeping food or drink in my mouth
_____ Episodes of coughing or choking when eating or drinking
_____ Food or drink seems to "go down the wrong way"?
_____ Food requires special preparation before eating. **Describe:** _____
_____ Food remains in mouth after swallowing
_____ Food gets "stuck" in my throat: **Describe:** _____
_____ Liquids come back through my nose when I swallow
_____ Other medical problems are related to the start of my swallowing problems. **Describe:** _____
_____ Recent diagnosis of a breathing problem (such as pneumonia). **Describe:** _____
_____ Wake up regularly at night coughing
_____ Wake up with a bad/sour taste in my mouth
Provide additional information that might be helpful in the evaluation or remediation process:

_____

_____

_____

CONSENT FOR TREATMENT: I hereby authorize Integrity Rehab to provide therapy services to _____ that have been ordered by my (his/her) physician and are under the direct supervision of a licensed health care professional. I also understand that it is my (his/her) right to accept or refuse medical treatments.

AUTHORIZATION OF RELEASE OF INFORMATION AND PAYMENT: In applying for payment under Title XVIII or Title XIX of the Social Security Act, or other third party payer sources, I certify that the information given by me or a person authorized by me is correct. This authorization and request shall begin on _____ (TODAY'S DATE), and continue until such time that it is revoked by me, my legal representative, physician or this clinic. I also agree if there are any changes to the billing information (i.e., change in insurance company or policy, becoming ineligible or eligible for Medicare and/or Medicaid, etc.) that I will notify the clinic immediately. If I fail to report changes with my insurance to Integrity Rehab's billing department I will be financially liable/responsible. I understand that I am financially responsible for all charges that my insurance company does not pay. I authorize the release of any information necessary in order to process any billing.

RELEASE OF INFORMATION/CONFIDENTIALITY: I hereby authorize any physician, hospital/medical facility, laboratory, or other health care provider to release to Integrity Rehab any information requested by them for the purpose of continuity of care. I also authorize Integrity Rehab to release any of my (his/her) health care information from them to other health care providers involved in my (his/her) care, or any facility where I (he/she) may be admitted for the purpose of continuity of care. A written consent from patient or legal representative is required to release medical information to persons not otherwise authorized by law (federal and state). **For pediatric patients I agree to the Pediatric Speech Therapy Procedures.**

NOTICE OF NON-DISCRIMINATION: Integrity Rehab does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, or national origin, or on the basis of disability or age.

GRIEVANCE/COMPLAINT PROCEDURE: Should I have a grievance or complaint; I understand that every attempt will be made to rectify the situation without fear of reprisal. I may contact the Clinic Director, Compliance Officer, or Administrator by calling (254) 699-3933 or emailing Compliance@IntegrityRehab.net. If the grievance or complaint is not resolved to my satisfaction, I may follow the printed "Consumer Information Notices" in the Reception area.

PHOTOGRAPHY: I **DO** ___ **DO NOT** ___ authorize Integrity Rehab to photograph, videotape, or audio record me (him/her) for medical education or reasons related to treatment and/or promotion of Integrity Rehab operations. Patient's name will not be used.

INFORMATION RECEIVED: I have reviewed a laminated copy of the following information to **read and understand:** 1) **Notice of Privacy Practices**, 2**) Cancellation and No-Show Policy,** and 3) **General Health** Guidelines**. I may request a copy to take home with me**. For **pediatric patients**, in addition to the preceding information, I have **reviewed** a laminated copy of **Pediatric Speech Therapy Procedures**.

In addition, the following NEW PATIENT INFORMATION is available upon request:

- Abuse, Neglect, and Exploitation
- Advance Directives
- Cell Phone Policy
- Children Policy
- Civil Rights
- Disaster/Emergency
- Employee Drug Testing
- Rights of the Elderly

I acknowledge that the information above has been provided to me or is accessible to me in my primary language, or via an interpreter.
I certify that the information I have provided in this registration packet is accurate and complete.

Patient signature and date

Authorized agent signature and date **Relationship to patient**