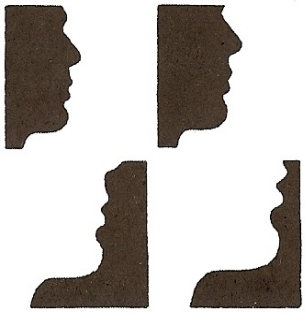

TALLAHASSEE SPEECH & LANGUAGE CENTER
MARY PELLEGRINO & ASSOCIATES
SPEECH LANGUAGE PATHOLOGISTS

3215 Capital Medical Blvd. / Tallahassee, FL 32308 / PH (850) 878-0609 / FAX (850) 877-1057

ADULT CASE HISTORY

Date_____

Patient's Name:_____ **Birthdate**: _____Age: _____

Address_____

City _____ State _____ Zip _____

Soc. Sec. # _____

Home # _____ **Work** #_____ **Cell #** _____

Place Of Employment _____

Insurance _____ ID # _____

Physician _____ Phone # _____

Referred By _____ Relationship _____

Name of Caregiver (if applicable)_____

Emergency Contact _____Phone _____

Information provided by: patient spouse other _____

I authorize Mary Pellegrino and Associates to leave messages at the phone numbers indicated above.

_____ _____

Responsible Party Signature Date

Social History

Occupation: _____ Employer: _____

Highest Degree Earned: _____ Date: _____

Is English your primary language? ____ Yes ____ No

Please answer the following questions regarding the patient's social and family background:

1. Married (how long?):_____

2. Number of children:_____

3. People living in the home:_____

4. Hobbies:_____

Assistive Devices:

__ Wheelchair
__ Hearing Aid
__ Dentures
__ Walker
__ Glasses / contact lenses
__ Positioning devices
__ Communication devices
__ Other

Diet:	Manner of Eating:	Diet Consistency:
__ Regular	__ Feeding self	__ Regular
__ Low fat	__ Needs assistance	__ Chopped
__ Low sodium	__ Uses hands	__ Puree
__ Other :	__ Uses utensils	__ Thickened liquids

Please answer the following questions regarding the patient's Medical History:

General Health: _____Excellent _____ Good _____Fair _____Poor

Do you have any medical diagnosis? If so, specify _____

_____

Current Medications Purpose Dose / Schedule

_____
_____
_____

Are you sensitive to latex? _____Yes _____No

Please check all that apply to you:

	Allergies		Dental Problems
	Frequent Laryngitis/Hoarsness		Epilepsy/Seizure Disorder
	Reading or Spelling Difficulties		Attention Deficit Disorder
	Vision Problems		Swallowing/Digestive Disorder
	Respiratory Difficulties (asthma, TB, etc.)		Heart Problems/Stroke
	Neurological Disorders		Cancer
	Mental Illness		Congential Disorder
	Hearing Problems		Facial Weakness
	Paralysis		Limb Weakness

Have you ever been seen by any of the following specialists. Check all that apply.

Neurologist Audiologist

Psychiatrist ENT

Psychologist Gastroenterology

Other

Please list physician's name and last date seen.

_____
_____
_____

Please list surgical procedures and dates.

_____
_____
_____

1). In your own words, please describe the problem.

2). When did the problem begin?

3). Has there been any change in the problem since it began?

4). What are the patient's personal goals for therapy (What do you want to change or improve)?

5). Please answer the following questions about the patient.

a. Is the patient : left handed _____ right handed _____

b. Is the patient capable of: writing _____ using utensils _____

c. Language spoken in the home other than English:_____

d. Describe any paralysis:

e. Any known vision problems (current or previous)?

f. Any known hearing problems (current or previous)?

g. Has the patient experienced any change in personality? If so, please describe:

6.) Please list any health related or other problems of which we should be aware?

_____
_____
_____

7.) Please list all professional services being received by the patient. (Provide names)

_____
_____
_____

8). Please answer the following questions regarding the family's response to the patient's problem.

a. How many people come into contact with the patient on a daily basis?

b. Briefly describe the family's attitude toward the problem.

c. What are the family's main problem or concerns regarding the patient's problem?

d. How do family members communicate with the patient?

e. Check all that apply:

_____ Patient initiates conversation.

_____ Patient makes wants and needs known.

_____ Patient participates in conversations.

_____ Patient is able to speak in sentences.

_____ Patient says words but no sentences.

_____ Patient communicates with gestures and sounds but no words.

_____ Patient does not communicate.

_____ Patient understands most of what is said.

_____ Patient understands something especially if spoken to in a slow rate.

_____ Patient does not understand much at all.

_____ Family members do not help the patient speak.

_____ Family members help the patient with a occasional word.

_____ Family members guess at what the patient wants.

_____ Family members do most of the talking for the patient.

_____ Family members do not communicate with the patient.

9. Please add any additional information relevant to the patient's problem.

OFFICE POLICIES AND PROCEDURES

Cancellations

- If for any reason you must cancel your appointment, a 24-hour notice is preferred. If any patient misses two appointments without prior notice, that patient will be removed from our schedule. There is a $30.00 fee for appointments missed without prior notice. Patients who are sick will not be seen for therapy sessions. It is at the discretion of the therapist to determine if a child is too sick to receive services.

Billing Policies

- Our office will file insurance as a courtesy for patients. Any balance left unpaid after 60 days will automatically become the responsibility of the patient. All patient balances over 30 days are subject to an 18% finance charge. Co-payment and deductible amounts must be paid at the time services are rendered. Speech therapy is considered a medical expense and may be a tax deduction.

Private Pay

- Our private pay fee scale is available to patients who do not have insurance coverage for speech therapy or for patients who have exhausted their insurance benefits. The fees for services are as follows:

Initial Evaluation- $350.00
1x per week- $300.00/month
2x per week- $550.00/month
3x per week- $650.00/month

- If you wish to pay per session, the per session fee is $80/per ½ hour session ($160.00/per hour)

Private pay amounts are due at the time of the **first session of each month.** Appointments that are cancelled with 24 hours notice must be rescheduled within the current month. Appointments that are missed without prior notice **will not be rescheduled.**

I have read and understand the office policies and procedures.

_____ _____
Responsible Party Signature Date

PATIENT RIGHTS AND MEDICAL RECORDS

Patient Rights

1. The patient has the right tot expect quality services and treatment in accordance with professional standards of practice.
2. The patient has the right to refuse treatment.
3. The patient has the r
ight to be treated with respect and dignity.
4. The patient has the right to be informed of any treatment that is being provided.
5. The patient has the right to receive education in reference to services being provided.
6. The patient has the right to confidentiality of all patient information.
7. The patient has the right to privacy during all phases of treatment.
8. The patient has a right to remain free of injury during all phases of treatment.
9. The patient has a right to disagree with and/or question services being provided in a respectful manner.
10. The patient has a right to make informed decisions before receiving treatment.
11. The patient has a right to file a grievance utilizing the grievance procedure.
12. The patient has the right to have all patient rights protected by the professionals.

I have read and understand the patient rights

_____ _____
Responsible Party Signature Date

Medical Records

1. All patient records will be kept confidential.
2. All medical records will be made available to insurance companies as necessary for treatment and payment purposes.
3. Records will be released to a third party only by written request of the patient.
4. All patients have the right to request records at any time.
5. Changes can be made to medical records by request of the patient to correct errors or incorrect information.

I have read and understand the medical records policy.

_____ _____
Responsible Party Signature Date

GRIEVANCE PROCEDURE

Mary Pellegrino and Associates makes every attempt to satisfy all patients with services provided. If, however, you have any complaints, we ask that you abide by the following procedures:

Your therapist will sit down with you, your guardian, or anyone else you choose and attempt to resolve the problem. Problems can sometimes be worked out by simply sitting down and discussing them. If this matter cannot be resolved to your satisfaction, Please present your complaint in writing. Our office will provide you with a written response to you grievance and both correspondences will be kept in our grievance log.

Your grievance must contain the following information to be maintained in our log:

1. Name of the person making the complaint.
2. The complainant's relationship to the person receiving the services.
3. Date of the complaint.
4. A clear description of the complaint.

This acknowledges that I understand the grievance procedure.

_____ _____

Responsible Party (print name) Date

_____

Responsible Party Signature

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name_____ Date of Birth_____

I,_____ give my consent for an exchange of information

between:

Mary Pellegrino and Associates
3215 Capital Medical Blvd.
Tallahassee, Fl 32308
ph (850) 878-0609 fax (850) 877-1057

and:

_____
Name of Primary care physician or entity to which records a**re to be released.**

_____
Street Address

_____
City State Zip

_____
Phone Fax

My signature means that:

1. I have read this authorization. I understand and agree to its contents.
2. I have been informed that no other information may be released without my written consent.
3. I have been informed that I may revoke this authorization by written statement at any time.

Signed:

_____ _____
Client (if not a minor) Witness

_____
Parent / Guardian (if a minor)

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, plus how you can get access to this information. Please review it carefully.

1. All patient records will be kept confidential.
2. Original records will not leave the facility.
3. Records will be released to a third party only by written request of the patient, parent or guardian.
4. All patients have the right to request copies or inspect their records at any time.
5. Requests for changes to medical records can be made at any time.
6. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or healthcare operations. This must be requested in writing.
7. We may use and disclose protected health information (PHI) about you in the following circumstances:
    - To provide treatment to you
    - To obtain payment for services
    - To conduct health care operations
    - Under certain circumstances without your authorization as required by law or in response to a valid subpoena
    - To provide appointment reminders
    - To contact you with information about treatment, services, products or healthcare providers
    - Under certain circumstances if you do not object or agree
8. You have several rights regarding you PHI:
    - The right to see and copy your PHI
    - The right to request amendments to your PHI
    - The right to a listing of non-routine disclosures we have made
    - The right to request restrictions on uses and disclosures of your PHI
    - The right to object to certain uses and disclosures
    - The right to request different ways to communicate with you
9. If you believe your privacy rights have been violated, you may file a complaint with the privacy officer at this facility or with the secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
10. You have the right to request restrictions in how we communicate with you via your home and work. All requests must be made in writing to the privacy officer and must specify how and where you wish to be contacted.

I have read and received a copy of the privacy practices.

_____ _____

Responsible Party Signature Date

CLIENT COPY

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, plus how you can get access to this information. Please review it carefully.

1. All patient records will be kept confidential.
2. Original records will not leave the facility.
3. Records will be released to a third party only by written request of the patient, parent or guardian.
4. All patients have the right to request copies or inspect their records at any time.
5. Requests for changes to medical records can be made at any time.
6. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or healthcare operations. This must be requested in writing.
7. We may use and disclose protected health information (PHI) about you in the following circumstances:
    a. To provide treatment to you
    b. To obtain payment for services
    c. To conduct health care operations
    d. Under certain circumstances without your authorization as required by law or in response to a valid subpoena
    e. To provide appointment reminders
    f. To contact you with information about treatment, services, products or healthcare providers
    g. Under certain circumstances if you do not object or agree
8. You have several rights regarding you PHI:
    a. The right to see and copy your PHI
    b. The right to request amendments to your PHI
    c. The right to a listing of non-routine disclosures we have made
    d. The right to request restrictions on uses and disclosures of your PHI
    e. The right to object to certain uses and disclosures
    f. The right to request different ways to communicate with you
9. If you believe your privacy rights have been violated, you may file a complaint with the privacy officer at this facility or with the secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
10. You have the right to request restrictions in how we communicate with you via your home and work. All requests must be made in writing to the privacy officer and must specify how and where you wish to be contacted.