New Patient Packet

Dear Patients, Parents or Guardians,

Thank you for choosing Azalea Rehab Services. Our commitment to quality service as therapists includes documentation and following our professional and state-mandated guidelines.

Please complete the following packet to the best of your ability. In addition, please include a copy of your insurance card(s), front and back, and a copy of the patient's prescription if available. Upon returning your completed packet to our facility someone will contact you to set up an appointment.

- ☐ New Patient Registration Form (Front and Back)
- ☐ Copy of Insurance card (Copy of Both Sides)
- ☐ Prescription for Speech Therapy or Occupational Therapy (Duration & Frequency)
- ☐ Liability Release
- ☐ Release of Information (Copies of Current IEP and/or Evaluation)
- ☐ Welcome Sheet
- ☐ Private Insurance and /or DDD Authorization

Thank you!
From all of us at Azalea Rehab Services

2301 Bemiss Rd.
Valdosta, GA 31602
Office: (229) 244-1667
Fax: (229) 244-8253
azalearehab@gmail.com

Adult Form

Case History

Patient's Name | Date of Birth

Address

City | Zip Code

Spouse (if applicable)

Home phone | Work Phone

Cell Phone | Other Phone

Emergency Contact Name | Emergency Contact Phone

Physician's Name

Physician's Address

Physician's Phone Number | Physician's Fax Number

Insurance

Insurance Address and Phone

Co-Pay | Member ID | Group Number

Name and DOB of Insured (if other than patient)

Referred By

When was the problem first noticed? By whom?

___

___

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Are there any other speech, language, or hearing problems in your family? Are there any other fine motor problems in your family? If so, please describe.

____

____

Adult Form

Medical History

Please list any Specialists/Physicians that you visit for care.

____

____

Illnesses, Injuries, Operations (Date, Severity, Complications):

____

____

Hearing Test Date: ____________ Results: ______________________

Vision Test Date: ____________ Results: ______________________

Allergies: ______________________________________

Current Medications: ______________________________________

____

Other Information: ______________________________________

____

Difficulty you experience (check all that apply):

- ☐ Swallowing
- ☐ Voice
- ☐ Hearing
- ☐ Speaking
- ☐ Understanding Others
- ☐ Memory
- ☐ Word finding
- ☐ Stuttering
- ☐ Performing Daily Routines
- ☐ Daily Self-Maintenance

Other: ______________________________________

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Onset date (when the problem first began): ____

When do you have the LEAST difficulty? ____

When do you have the MOST difficulty? ____

How do you cope? ____

____

What is YOUR goal for therapy? ____

____

Have you had therapy previously: Yes / No

____

Location Date(s)

Do you have any adaptive equipment (brace, walker, wheelchair, special cup for drinking, electrolarynx, etc):

____

____

Other (Please include any other information you feel would help us better understand your difficulties):

____

____

____

____

Person completing form Relationship to client

____

Signature Date

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Please list your medication information below.

Medication: Prescription, Over the Counter, Vitamins, Herbals, Dietary Supplements	Dosage	Frequency (times per day)	Route (Oral, Injectable, Transdermal, Inhale) Patients with Medicare must complete	Reason for Medication

Please describe your smoking history.

- ☐ I am a current smoker, and I smoke __________ packs per day.
- ☐ I am a former smoker, and I quit on ______/______/_____.
- ☐ I have never smoked.

Adult Form

Speech & Language Skills

1. Do you have difficulty expressing your wants and needs? If yes, please explain.

____

____

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2. Do others find you difficult to understand? If yes, please explain.

____

____

3. Do you find it hard to understand others? If yes, please explain.

____

____

4. Do you have short-term and/or long-term memory difficulties? If yes, please explain.

____

____

5. Is word-finding difficult (remembering names of objects/people)? If yes, please explain

____

____

6. Do you have difficulty with reading or writing? If yes, please explain.

____

____

7. Has there been any change to your voice (hoarse, breathy, loss of volume)? If yes, please explain.

____

____

Adult Form

Swallowing Skills

Please indicate if you have had any difficulty with any of the following:

- ☐ Chewing food
- ☐ Managing liquids
- ☐ Coughing
- ☐ Choking
- ☐ Drooling
- ☐ Increased meal times
- ☐ Holding cup/utensils
- ☐ Moving food to back of mouth
- ☐ Watery eyes when eating or drinking
- ☐ Clearing food/liquid from mouth
- ☐ Other: ____________________

____

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Adult Form

Clinical Dysphagia Background

1. Please describe your swallowing problem.

____

____

2. Are there any current diagnoses of the problem? If yes, please explain.

____

____

3. What is your past medical history regarding swallowing issues?

____

____

Adult Form

Vocal Hygiene & Abuse

Please mark any behaviors that apply to you.

- ☐ Excessive speaking
- ☐ Job-related speaking
- ☐ Shouting/yelling
- ☐ Excessive laughing
- ☐ Throat clearing
- ☐ Cough
- ☐ Heavy lifting/pushing/pulling
- ☐ Active sports fan
- ☐ Heartburn/reflux
- ☐ Constipation
- ☐ Emotional/mental stress
- ☐ Alcohol use
- ☐ Other: ____________________

Please describe your smoking history.

- ☐ I am a current smoker, and I smoke __________ packs per day.
- ☐ I am a former smoker, and I quit on ______/______/_____.
- ☐ I have never smoked.

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Assignment of Benefits

____

Patient Name Date

____

Employer

____

Insurance Company

____

Social Security No. / ID No.

I hereby instruct and direct ______________________________ Insurance Company to pay by check made out and mailed to:

Azalea Rehab Services

Or, if my current policy prohibits direct payment to the provider, I hereby also instruct and direct you to make out the check to me and mail it as follows:

2301 Bemiss Rd., Valdosta, GA 31602

for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Dated at ________________ this ___________ day of ____________________, 20_____.

____

Signature of Policyholder Signature of Witness

____

Signature of Claimant, if other than Policyholder

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Patient Consent Form

The undersigned hereby give permission to Azalea Rehab Services to make photographs, videos, or recordings for use in evaluations, treatment planning and for possible publication in various scholarly journals, and for academic and teaching purposes including lectures and demonstrations or for the website. Azalea Rehab Services also reserves the right to allow students to observe treatments performed on its clients.

The undersigned hereby waives any and all claims against Azalea Rehab Services, its employees and agents in any matter whatsoever relating to the said photographs, films, videotapes, sounds recordings, written material, and/or student observations and approves their use.

____

Patient's Name Date

____

Signature of Patient, Parent or Guardian Relation

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Cancellation/No Show Policy

For Evaluations & Therapy Appointments

1. Cancellation/No Show Policy for Evaluations and Therapy Appointments

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much-needed treatment.

Patients will be discharged from Azalea Rehab Services following (3) *No-Shows or (5) **Cancellations within a 2-month time period.

> *A “no-show” is missing a scheduled appointment without prior notice
>
> **A “cancellation” is removal of an appointment from our schedule after notifying Azalea Rehab Services at least 3 hours in advance.

2. Late Arrivals

We understand that delays can happen, however, we must try to keep the other patients and therapists on time. **If a patient arrives 10 minutes past their scheduled time we will have to reschedule the appointment.**

3. Account Balances

We require that Self-Pay patients bring their account balances to zero (0) every two (2) weeks prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to Heather Delaney to review their account and concerns.

Patients with balances over $100 must arrange payment prior to future appointments being made.

____

Print Patient’s Name | Print Parent’s/Guardian’s Name

____

Patient/Parent/Guardian Signature | Date