Dymond Speech & Rehab., P.A.

Patient Registration Information

Client's Name: First _____ Middle _____ Last_____
Street Address: _____ Mailing Address: _____
City : _____State:_____ Zip code: _____ Sex:_____ Marital Status: _____
Home Phone: ( ) ____-_____ Cell: ( )_____-_____ Other: ( )_____-_____
Date of Birth: __/__/___ Social Security #: ___-__-____ Employer: □ NA/ Child _____

Primary Concern: _____

Referring Physician: Dr._____ _____ Practice Name:_____City: _____Phone: (__) ___-_____

Person Responsible for the Account: First _____ Middle _____ Last_____
Street Address: _____ Mailing Address: _____
City : _____State:_____ Zip code: _____
Home Phone: ( ) ____-_____ Cell: ( )____-_____ Other: ( )_____-_____
Date of Birth: __/__/__ Social Security Number: ____-___-_____ Relationship to Patient: _____
Driver's License Number: _____Employer: _____

Primary Insurance Holder:
First _____ Middle _____ Last_____
Street Address: _____ Mailing Address: _____
City : _____State:_____ Zip code: _____ Sex: _____
Employer:_____Date of Birth: ___/___/____ Social Security Number: ____-___-_____
Home Phone: ( ) ____-_____ Cell: ( )_____-_____ Other: ( )_____-_____

Insurance Card Information:
Primary Insurance: (Circle One) *BCBS MEDCOST MEDICAID TRICARE* Other: _____
Group Number: _____ Policy/ID Number: _____
Address: _____ City: _____ State: ___ Zip: _____ Phone: ( )___-_____

Is the patient insured by another policy?
Secondary Insurance: (Circle One) *BCBS MEDCOST MEDICAID TRICARE* Other: _____
Group Number: _____ Policy/ID Number: _____
Address: _____ City: _____ State: ___ Zip: _____ Phone: ( )___-_____

Caregiver Information: (if applicable)
Mom: Name: _____ Employer: _____
Home Phone: ( ) ____-_____ Cell: ( )____-_____ Work Phone: ( ) ___-_____Ext: _____
Dad's Name: _____ Employer: _____
Home Phone: ( ) ____-_____ Cell: ( )____-_____ Work Phone: ( ) ___-_____Ext: _____
Guardian Name: (if applicable)_____
Home Phone: ( ) ____-_____ Cell: ( )____-_____ Work Phone: ( ) ___-_____Ext: _____

Emergency Contact's Name: _____ Relation: _____
Home Phone: ( ) ____-_____ Cell: ( )____-_____ Work Phone: ( ) ___-_____Ext: _____

Dymond Speech & Rehab., P.A.

General Biographical Data:

Name **Age** **Occupation** **Education** **Living** **Deceased**

Father:_____

Mother:_____

Number of brothers & sisters_____ Age_____

Number of person living in your home_____ relationship_____

Veteran yes or no Dates of service_____

Medical History (Please answer all that apply):

Were you recently hospitalized? _____ If yes, dates_____

When did trauma occur? (Accident, illness, operation, etc.)_____

Did you receive rehabilitation? _____If yes, location & dates:_____

Personality changes as result of injury; if any?_____

_____

Describe personality characteristics as your family members might report_____

_____

Please list significant medical history with dates of onset: (stroke, Parkinson's, Dementia, etc.)_____

_____

How would you describe your present ability to communicate and function in general:_____

_____

Do you have any hearing issues? If so, please describe: _____

What is your main concern today? _____

How long have you been experiencing this problem? _____

Who referred you to our clinic? _____

Why are you pursuing therapy at this time? _____

Please list current medications you are taking: _____

Do you have any allergies? If yes, please describe: _____

Check the following if applicable:

_____Paralysis (specify parts of body involved)_____
_____plate inserted in head
_____fainting
_____dizziness
_____loss of consciousness; for how long?_____
_____convulsions (are they controlled)?_____
_____easily tired
_____difficulty with eating
_____visual impairment
_____auditory impairment
_____headaches (severity, forms, frequency)_____
_____high fever
_____red measles
_____Other: _____

Occupational Data:

Are you presently employed? Yes or No If yes, describe your job duties:_____
_____
_____
_____

Educational History:

Highest grade completed_____ Major interest in school_____

Subject (s) most liked_____

Did you repeat a grade? Yes or No Which grade?_____Reason?_____

Where you placed in any special education classes?_____

For which subjects_____

Extra-curricular activities_____

Social History:

Active in following organizations:_____
_____

Hobbies and special interest:_____
_____

Do you smoke or use tobacco in any for? Yes or No If yes, for how long?_____

Do you stutter? Yes or No If yes, how long?_____ Have you ever received therapy for stuttering? Yes or No

Do you still have periods of dysfluency? If so, describe_____
_____

Do you have difficulty expressing yourself verbally? If so, describe_____
_____

Dymond Speech & Rehab., P.A.

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL RECORDS MAY BE USED OR DISCLOSED AND HOW YOU CAN ACCESS YOUR RECORDS. PLEASE REVIEW IT CAREFULLY.

Dymond Speech & Rehab., P.A.'s Legal Duty

Dymond Speech & Rehab, P.A.. is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Dymond Speech & Rehab, P.A.. uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, *Dymond Speech & Rehab, P.A..* may use your personal health information to contact you to provide appointment reminders, information about treatment alternatives, or other health related benefits/offers that could be of interest to you.

Dymond Speech & Rehab, P.A.. may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Dymond Speech & Rehab, P.A..'s policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Dymond Speech & Rehab, P.A.. may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHT

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. ***Dymond Speech & Rehab, P.A..*** will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that ***Dymond Speech & Rehab, P.A..*** may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Dymond Speech & Rehab, P.A.'s health information practices or if you have a complaint, please contact the following person:

Dymond Speech & Rehab, P.A.
Brett Dymond – Practice Manager
113 Hillcrest Drive ***310 West Street***
Sanford, NC 27330 ***Pittsboro, NC 27312***

Telephone: 919-777-0240 **Fax: 919-777-0499** **DymondRehab@windstream.net**

Dymond Speech & Rehab, P.A..

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Dymond Speech & Rehab, P.A.'s Notice of Information Practices. I understand that Dymond Speech & Rehab, P.A. may use or disclose my personal health information for the purposes of:

- Carrying out treatment
- Evaluating the quality of services provided
- Any administrative operations related to treatment or payment
- Appointment reminders
- Information about treatment alternatives
- Other health related benefits/offers

I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Dymond Speech & Rehab, P.A. will consider requests for restrictions on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Dymond Speech & Rehab, P.A.'s Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____

Patient Name

_____

Signature

_____

Date

Financial Agreement
Please initial each line and sign the bottom of the page

_____ I understand that my insurance will be filed and any payment will be paid directly to Dymond Speech & Rehab., P.A., unless otherwise agreed to in writing.

_____ I understand that authorization or verification of benefits does not guarantee payment.

_____ I will be responsible for the total amount not paid by third party reimbursement.

_____ I acknowledge that payment is due at the time of service, unless other arrangements are made. If payments are not made at the time of service and a payment arrangement has not been set up then I understand that therapy sessions will be cancelled/placed on hold until payment is made.

_____ I agree to be responsible for any charges incurred on my behalf. I accept full financial responsibility for all charges not covered by insurance.

_____ I understand that it is my responsibility to notify Dymond Speech & Rehab, P.A. any time there is a change in address, phone number or insurance coverage.

_____ I understand that these notifications must be made as soon as possible or that I will be held responsible for any payments not made by third party reimbursement.

_____ I authorize release of information pertaining to the diagnosis and course of treatment to Dymond Speech & Rehab, P.A. by the patient's physician and any other therapy service providers involved in the patient's care. I also authorize the release of information to the patient's physician and any other agencies related to reimbursement issues.

_____

Patient's Signature (or parent if child under 18) **Date**

_____

Staff Signature **Date**

Attendance Agreement
Please initial each line and sign the bottom of the page

Our mission at Dymond Speech & Rehab, P.A. is to treat, educate, and improve the quality of lives for all of our patients and families. This includes regular attendance to therapy which establishes a routine and ensures progress toward your goals. We want you to view your therapy appointment as a regularly scheduled event.

_____In fairness to those waiting for services please be advised of our attendance policy listed below:
1st No Show – you will receive a call from your therapist. If a message is left, they require that you call back within 24 hours to confirm the next therapy appointment.
2nd No Show – you will receive a letter in the mail from us.
3rd No Show – you will be taken off our schedule immediately and may be discharged from our clinic.

_____We expect at least 90% attendance for therapy sessions for adequate progress to be made.

_____Any patient who does not show up for a scheduled appointment and has not called 24 hours in advance to cancel the appointment will be personally charged a $35.00 fee. Insurance does not cover this fee. The fee must be paid prior to being seen by a provider in this Practice.

_____Your therapy sessions are recurring appointments and must be viewed as such. We ask that you schedule other appointments around your therapy schedule. If this is impossible for an appointment, please contact us as soon as possible so that we can reschedule your therapy appointment for that week.

_____If you cancel your appointments frequently, your status will be reviewed to determine if we will be decreasing the frequency of services or discharging you from our clinic.

By signing below, I _____ agree that I have read and understand the above stated attendance agreement.

_____

Patient's Signature (or parent if child under 18) **Date**

_____

Staff Signature **Date**