Dymond Speech & Rehab., P.A.

Patient Registration Information

Client's Name: First _____ Middle _____ Last_____
Street Address: _____ Mailing Address: _____
City : _____State:_____ Zip code: _____ Sex:_____
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: _____
May we ask who referred you to our clinic? _____

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

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

Dymond Speech & Rehab, P.A.
Developmental Case History:

Child's Name_____ Age: _____ Date of Birth:___/____/____

Family/School Information: Does child live with both parents? Yes or No _____
Names and ages of siblings:_____
Name of pre-school, daycare, or school:_____
Are you thinking of using pre-school? _____

Birth History: Was child born prematurely?_____Child was born at _____weeks gestation.
Any complications during pregnancy? If so, please list_____
Any complications immediately following birth? If so, please list_____

Medical History: Did your child pass their hearing screening at birth? Yes or No
Have they had a recent screening/evaluation? Yes or No Did they pass the recent screening/evaluation? Yes or No
Is your child current with his/her immunizations? Yes or No
Has your child had tubes in the past? Yes or No When? _____
Do they currently have tubes? _____
How many ear infections have they had? _____
Are they being followed by an Ear, Nose, & Throat Doctor on a regular basis? Yes or No; Dr. _____
Has your child been hospitalized for any reason? _____
Circle all that apply: tonsillitis high fever meningitis seizures allergies measles croup chronic colds
Does your child have any vision issues? _____
Does your child have any allergies to medications or foods? _____
Does your child have any medical diagnoses? _____ Date of diagnosis_____

Developmental History:
List the age when you child began: Crawling___Walking____ First Words _____ Combining words_____
Did your child babble as an infant? Yes or No
If you child is talking, what percent of their speech is understood? Familiar listeners- ___ % Unfamiliar listeners- _____%

Feeding/Eating History: Did your child have any difficulties feeding after birth? If so, please explain_____
Is your child a picky eater? Yes or No _____
When did your child stop using a bottle?_____ Pacifier?_____
Does your child have any stomach or Gastrointestinal issues? Yes or No _____
Do they have any food allergies or special diets? Yes or No _____

Play/Social Information: Does your child play appropriately with toys? Yes or No _____
Does your child engage in any odd behaviors? Yes or No _____
Does your child have difficulty attending or concentrating? Yes or No _____
Does your child have any significant problems with behavior? Yes or No _____

Sensory/Motor Development: Does your child appear awkward or clumsy? Yes or No _____
Does your child seem to dislike certain type of textures (examples does not like getting dressed, hates tags in clothes, does not like water)? Yes or No _____
Does your child shy away from trying new activities? Yes or No _____
Please list dates and places of any other evaluations (example: DEC, neurologist, occupational therapy, ECI, etc.) _____
_____
Does your child get any services from your local school system? Yes or No
What services does your child get through the school system?
PT- Frequency: ___ times per _____ for ____ mins
OT- Frequency ___ times per _____ for ____ mins
ST- Frequency ___ times per _____ for ____ mins

Name: _____ Date:_____ Relationship to Child:_____

Financial Agreement
Please initial each line and then 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 or the behalf of my child. 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 then 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 child's goals. We want you to view your child's 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 – your child 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.

_____If your child is seen in a daycare or school setting, you must notify us any day your child will not be there. While we may see other children in the same daycare or school, we must know if your child will not be there so we can adjust our schedules accordingly.

_____Your child's 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 child's status will be reviewed to determine if we will be decreasing the frequency of services or discharging them from our clinic.

By signing below, I _____ parent/guardian of
_____ 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**