Contact Person (If other than patient)	Relationship to patient (If POA provide paperwork)	Contact Phone

PATIENT INFORMATION

Full Legal Name (First) (Middle) (Last)			Name Normally Used (Nickname)
Address (Number) (Street) (Apt. No.)			Preferred Phone
City	State	Zip	Email Address
Date of Birth	Age	Sex	2ndary Phone
Marital Status: Married Widowed Single Divorced			Social Security Number
Employer Name			Business Phone (Including Extension)
Referring Physician			Primary Care Physician

Why did you choose Elder Care? **Physician Referral** **Billboard Ad** **Newspaper/Prime Times** **Friend/Relative Referral** **Previous PT Patient w/Positive Outcome** **Television Ad/Commercial** **Other:**

Are you currently receiving or have you received services through a home health agency in the last 30 days? **Yes** **No**

If yes, Home Health Provided By: Date Released: / /

SPOUSE'S INFORMATION

Full Legal Name (First) (Middle) (Last)

Address (If Different From Above)	City	State	Zip	Home Phone

Employer Name	Business Phone (Including Extension)

INSURANCE INFORMATION

Primary Insurance Company Name	ID/Certificate No./Group No.
Secondary Insurance Company Name	ID/Certificate No./Group No.

Other Insurance Information/ Guarantor/Trust Officer Information (Name, address, phone)

EMERGENCY INFORMATION (SOMEONE NOT LIVING WITH YOU)

Person to Notify in Case of Emergency	Relationship

Address (Number) (Street) (Apt. No.)

City	State	Zip

Home Phone	Work	Cell Phone

INFORMATION FOR THE PATIENT

We accept Medicare assignment which means that our charges are predetermined by Medicare based on the extensiveness of our services. We will always notify you if we schedule or prescribe any services that are not currently covered by Medicare. We bill Medicare direct and will file with any secondary insurance you may have. You will probably receive a statement from Medicare reflecting your visit to Elder Care. You will receive a statement from us for any balance you are responsible for such as annual deductibles and/or coinsurance once claims have processed by both Medicare and any secondary insurance you may have.

Office Information: **NEW** / RETURN **SCRIPT** / DA REASON:_____

APPT DATE/TIME: _____ PT: _____ ☐ **WEB** ☐ **SCHED** ☐ **CASE** ☐ **PT** ☐ **VOB**

Name_____

Appointment Date _____ **Check-in Time** _____

Appointment Time_____

Please bring the following to your SPEECH THERAPY APPOINTMENT:

1) Physician prescription (if available)

2) List of medications you are currently taking, including over the counter.

3) The enclosed paperwork

4) Medical insurance cards

5) List of upcoming appointments. This will help us to avoid appointments you have already made when scheduling future appointments.

Please call if you need to reschedule the above appointment. **In order to provide the highest quality of care, late arrivals cannot be seen.** We thank you in advance for your understanding. We look forward to providing you with the best of care**. If you have had any recent surgery or imaging please call your Dr.'s office and request that the report be sent to Elder Care speech therapy department at 918-336-8519.**

We appreciate you choosing Elder Care Speech Therapy!

Elder Care Speech Therapy
1223 Swan Drive
Bartlesville, OK 74006
Phone 918-766-0391 –Speech Therapy Scheduling
Fax 918-336-8519
www.aboutеldercare.org
Excellence in Senior Care Since 1983

Speech Therapy - Intake

General

Name: _____ DOB: _____Age: _____

Employment: _____ Residence Type: _____

Social Activities: _____

Significant People (family members, roommates, caregivers, etc)

Name	*Relationship/In Household?*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medical Diagnoses: _____ _____

_____ _____

Other pertinent medical information, including neurological events:

_____

_____

_____

_____

Smoking History: NO YES _____

Past Therapies: _____

_____

Are you attending or receiving any of the following Elder Care services?

- ❑ Daybreak
- ❑ Care Management
- ❑ Golden Opportunities
- ❑ Brighter Living Services
- ❑ Caregiver Support Program
- ❑ Physical Therapy

Symptoms

Describe your problem in your own words: _____

_____

_____

Mark/list characteristics of your symptoms:

Speech

- ❑ Dysfluencies/stuttering
- ❑ Mixing up sounds in words
- ❑ Issues with voice (please circle): volume/strain/quality/resonance
- ❑ "Mumbling" or imprecise speech sounds
- ❑ Rate (please circle): fast/slow
- ❑ Other: _____

Language

- ❑ Effortful
- ❑ Word-finding errors
- ❑ Mixing up words
- ❑ Short, agrammatic utterances
- ❑ Long, fluent utterances
- ❑ Meaningless utterances
- ❑ Difficulty comprehending
- ❑ Other: _____

Cognition: *Difficulty with…*

- ❑ Memory
- ❑ Processing information
- ❑ Attention
- ❑ Organization
- ❑ Problem solving
- ❑ Other: _____

Swallowing

- ❑ "Stuck" sensation
- ❑ Discomfort (please circle): Pain/Burning
- ❑ Multiple swallows required
- ❑ Choking (please circle): liquids/soft, moist food/hard, dry food
- ❑ Oral problems (please circle): drooling/control while chewing/lip closure/tongue coordination
- ❑ Other: _____

In your opinion, what would make the biggest difference in your life currently (your therapy priority)?

_____

_____

ELDER CARE SPEECH THERAPY PATIENT AGREEMENT

INFORMATION DISCLOSURE

I hereby consent for Elder Care and its staff to use my medical and billing information for treatment, payment, and health care operations. I consent for the release of all or part of my medical and billing information for this period of care to any insurance carrier, workers' compensation carrier or self-insured employer group responsible for paying any part of the Health System charges.

This disclosure for consent may be **revoked in writing** at any time. This revocation cannot apply to information already released based on this consent or to disclosures required by State and Federal laws. The person or organization receiving this information could re-release the information to others and federal law would no longer protect it. I release Elder Care, its staff, employees, officers and directors from any responsibility for such re-release. Contact the speech/physical therapy department at 918-776-0391 for further information or to obtain a copy of your HIPPA rights.

ASSIGNMENT OF INSURANCE BENEFITS

I agree that insurance benefits for Elder Care charges payable to the insured are to be made payable to Elder Care. Any payments received for this period may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits.

FINANCIAL RESPONSIBILITY

In consideration for the services provided me, payment is guaranteed for any amount due or such services provided by Elder Care at the Elder Care billed rates. The full amount of such charges, applicable insurance deductible or co-insurance is the responsibility of the Patient or Personal Representative as signed below.

RELEASE OF RESPONSIBILITY

Elder Care is held harmless from any loss, injuries, damages, claims, or actions that may arise out of my use of personal equipment/items.

☐ I hereby certify that I have read each of the statements and have had each item explained to me. I further certify that I am the patient or I am duly authorized by the patient to accept and be bound by the terms of this Patient Agreement.

Signature Relationship (if not self) Date

CURRENT MEDICATION LIST

Name_____ Date_____

- **Complete the information below regarding all medications you are currently taking.**
- **Be certain to list both prescription and non-prescription medications, including any herbals or supplements you take.**

Medication	Dosage	How Often	Route

Authorized Speech Therapy Information Release

☐ I DO NOT authorize Elder Care Speech Therapy to release details of my treatment to anyone.

☐ I Authorize Elder Care Speech Therapy to release details related to my medical treatment to the individual(s) listed below upon their inquiry:

Name Relation

_____

_____

_____

_____

_____

_____

_____

_____ _____

Patient Signature **Date**