BABEL THERAPY, PLLC

Patient Information and Financial Authorization

Patient Name:_____ **Date of Birth:**_____
(First) (Last) (Middle)

Address:_____
(Street) (City) (State) (Zip)

Phone: **Home:**_____

Cell:_____

Work:_____

E-mail:_____

Patient Social Security #_____-_____-_____

***required for commercial insurance, Medicaid and Medicare billing**

Patient: Single ( ) Married ( ) Divorced ( ) Widowed ( ) Dependent ( )

Parent/Guardian Name:_____

Name of Insurance (PRIMARY):_____

Policy or Group #:_____ **Insurance Phone:**_____

Name of Insured:_____ **Relationship to Patient:**_____

Insured Party's Date of Birth:_____

Employer:_____ **Employer Phone:**_____

Employer Address:_____

Name of Insurance (PRIMARY):_____

Policy or Group #:_____ **Insurance Phone:**_____

Name of Insured:_____ **Relationship to Patient:**_____

Insured Party's Date of Birth:_____

Employer:_____ **Employer Phone:**_____

Employer Address:_____

IN CASE OF AN EMERGENCY

Notify:_____ **Phone:**_____
Cell ( ) Home ( ) Work ( )

Relationship to Patient:_____

Name of Nearest Relative:_____ **Phone:**_____
Cell ( ) Home ( ) Work ( )

Address_____
(Street) (City) (State) (Zip)

Payment In Full Is Required At Time of Service

I agree to be responsible for payment of services.

Signature **Date**

I authorize release of any medical information necessary to process my claims.

Signature **Date**

I authorize payment of medical benefits to Babel Therapy, pllc for services provided.

Signature **Date**

Witness Signature **Date**

BABEL THERAPY, PLLC

CURRENT MEDICATION LIST

Patient Name:_____ ID number:_____

Allergies: ☐ No Known Drug Allergies (NKDA) ☐ Food Allergies: _____

☐ Other:_____

Date	Medication	Dosage/Frequency	Route of Administration

15260 Highway 105
Suite 225
Montgomery, TX 77356
PH: 936.703.5064
FX: 1-844-559-5504
www.BabelTherapy.com

CASE HISTORY - CONFIDENTIAL INFORMATION

Patient Name: _____

Today's Date: _____

Person completing this form: _____

Relationship to patient: _____

Who referred you to Babel Therapy? _____

Reason for Visit: _____

Medical Diagnosis: _____

Physician Name:_____ Phone Number: _____

Address: _____

MEDICAL HISTORY

Past surgeries: _____

Past hospitalizations: _____

Other Physical or Medical Conditions: _____

_____

_____

Wears glasses ☐YES ☐NO Legally Blind ☐YES ☐NO

Hearing impairment, if yes please describe _____

Wears hearing aids ☐YES ☐NO

COMMUNICATION SKILLS

At what level can patient currently communicate?

- ☐ Few familiar signs
- ☐ Pointing
- ☐ Gestures
- ☐ Picture Exchange
- ☐ Picture symbols
- ☐ Vocalizations
- ☐ High tech communication device (Dynavox, Tobii, iPad ect)
- ☐ Verbal but difficult to understand
- ☐ 1-2 words

Other: _____

Primary mode of communication is: _____

What does he/she do when his message is not understood?

Has the patient had speech therapy in the past? **If yes, please describe what was worked on and when the patient last had therapy.**

If yes, when was his/her last evaluation (month/year): _____

Has the patient had a communication device in past such as an iPad with communication application, Tobii,

DynaVox or Prentke Romich device? YES NO **IF YES, PLEASE PROVIDE NAME AND MANUFACTURER**

How well is the patient understood by: (i.e., what percentage of the time 0%, 25%, 50%, 75% 100%)

Mom: [redacted] Dad: _____ Younger siblings: _____ Older siblings: _____

Peers: _____ Extended family: _____ Unfamiliar adults: _____

Spouse: _____

Describe what it is like to have a conversation with the patient:

_____

_____

On average long are the his/her sentences? (circle)

single words 1-2 words 3-4 words 5+ words

Does the patient have any difficulty understanding you? (describe) _

Does the patient have difficulty following directions? (describe) _

Any speech or hearing problems in the immediate or extended family (explain)?

What is the patient's living situation? (family home, foster care, group home, ect?)

What activities does the patient enjoy doing?

Where does the patient enjoy going?

Regular responsibilities:

What motivates the patient most?

DAILY ACTIVITY SETTING

Does the patient attend school or a day habilitation program during the week?

Please provide NAME, ADDRESS, CONTACT PERSON AND PHONE NUMBER for school or day hab program:

Is the patient employed?

If therapy is recommended, what is the patient's availability for therapy visits? Include days, times, location (home, school, work, day hab program ect)

Functional Skills

Pleasemarkwhetherthepatientcompletesthefollowingtasksindependently(I),withassistance(A),requires maximal assistance (M): _ dressing _ feeding self _ toileting . personal hygiene

_ bathing/showering walking; if assisted what is used? _

Is the patient left or right handed?_____Able to use: open cup ☐ spoon ☐ straw ☐

Any difficulty? (Y/N) Swallowing:_____Chewing:_____Drinking:_____

Blowing:_____Drooling:_____

With whom does the patient interact with on a regular basis?

Does the patient show unusual behavior (explain)?

Does the patient receive other therapies such as physical, occupational, behavioral therapy? If so what is the frequency of visits?

OTHER

What do you hope to have happen as a result of this evaluation?

_____

Does the report need to be sent to specific agencies? If yes, provide: contact name, phone, fax, address of Agency. _

_____

Anything else you would like us to know?_____

_____

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CONSENT TO COMPLY WITH FEDERAL HIPAA ACT

Patient Consent for Use and Disclosure of Protected Health Information

With my consent and signature, Babel Therapy, PLLC may use and disclose protected health information about me or my child to:

1. Carry out treatment, payment, and healthcare operations (services).
2. Call my home or other designated locations and leave a message on voice mail in reference to any items (i.e. appointment reminders, insurance items, references to clinical care of laboratory results, etc.) that will assist in the practice of medical care for me or my child.
3. Mail to my home or other designated address any item (i.e. appointment reminder cards, patient financial statements, etc.) that will assist in practice of medical care form me or my child. Such correspondence is to be marked personal and confidential.
4. Send or transmit email to any location provided by me for all above similar items and purposes.
5. To use and/or disclose protected health information about me or my child to/with third parties involved in mine or my child's care. Such parties may include, but are not limited to, insurance companies, hospitals, specialty physicians, and laboratory personnel. I may specifically describe the type of information (i.e. dates of services, level of detail, origin of information, etc.) subject to disclosure and may revoke this permission at a time and date chosen by me. By providing a written statement to the privacy office of Babel Therapy, PLLC, I may revoke this permission; however, Babel Therapy, PLLCmay decline to provide further treatment to me or my child. Babel Therapy, PLLC may also decline further treatment to me or my child should my restrictions on the type of third party information, in the center's opinion, impede medical care of me or my child.

I have the right to review the Notice of Privacy Practice Manual of Babel Therapy, PLLC. Babel Therapy, PLLC may revise its manual and procedures at any time deemed necessary, and I may request from time to time, in writing, a copy of such changes, should these changes directly relate to mine or my child's care.

I have the right to request that Babel Therapy, PLLC restrict how it uses or discloses mine or my child's health information. However, as state previously, Babel Therapy, PLLC is not required to agree to my restrictions. If Babel Therapy, PLLC accepts my restrictions, Babel Therapy, PLLC is then bound by the restriction in the agreement, setting forth the restricted information until providing me, in writing, a cessation of such agreement.

I may revoke this entire consent, in writing, at any time. If I do not sign this consent, or revoke this consent, Babel Therapy, PLLC, in their sole discretion, may decline further treatment for me or my child.

The Federal HIPPA (Privacy Act) of 2001 was created to protect mine and my child's health information. I understand this must be accomplished within the provisions and rules set up by Babel Therapy, PLLC to fulfill federal law. I may request to review the manual which spells out these provisions. Babel Therapy, PLLC will comply with this law to preserve privacy. If compliance with this law impedes the medical care of the patient, Babel Therapy, PLLC may decline to provide further care. Babel Therapy, PLLC will strive to provide information so that I may make an informed decision concerning the privacy of mine or my child's medical information.

_____
Signature of Parent or Legal Guardian of Minor Child

_____ _____ _____
Patient's Name Date of Birth Date of Signature

_____ _____
Printed Name of Signature Above Initials of Witness

3107 Willowbend Rd.
Montgomery, TX 77356
PH: 936.703.5064
FX: 936.703.5065
www.BabelTherapy.com

CONSENT TO EXCHANGE INFORMATION

Patient's Name: _ Date of Birth: _

Current Address: _____

Telephone Number(s): _____

I hereby give my consent for the Babel Therapy, PLLC to exchange information with:

(Name and Address of Agency/Individual)

_____

_____

_____

Information exchanged may include but is not limited to speech/language and hearing records, medical reports, academic information and program planning. Information may be shared through written reports, by phone, fax or in person.

All of the information I hereby authorize to be exchanged with the above will be held strictly confidential and cannot be released without my written consent. I understand that I have the right to inspect and copy the information to be disclosed. I understand that I may withdraw this authorization at any time.

This request is effective up to and including six (6) months from the date of signature.

☐ By checking this box, you authorize Babel Therapy, PLLC to periodically send you, via email or U.S. mail, helpful information related to communication disorders, special promotions the Practice may have to offer, and/ or information about special fundraising events to benefit the Practice.

_____ _____

Signature of Consenting Party **Relationship to Patient (must be legal guardian/conservator)**

_____

Date