



ADULT REGISTRATION FORM
(PLEASE PRINT)

Today's date:		Email:	
PATIENT INFORMATION			
Patient's last name:		First:	Middle:
		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Dr. <input type="checkbox"/> Ms.
		Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Nickname):	Birth date: / /
			Age: Sex: <input type="checkbox"/> Other <input type="checkbox"/> Male <input type="checkbox"/> Female
Street address:		Cell phone no.:	Home phone no.: ()
P.O. box:	City:	State:	ZIP Code:
Occupation:	Primary Care Provider (PCP):		PCP phone no.:
	Send your reports to PCP: <input type="checkbox"/> Yes <input type="checkbox"/> No		()
Chose clinic because/Referred to clinic by (please check one box): <input type="checkbox"/> Dr. _____			<input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital
<input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Close to home/work <input type="checkbox"/> Veterans Affairs (VA) <input type="checkbox"/> Other			
Please list all immediate family members: Spouse/ Partner: _____			
Children & Age: _____			
Siblings & Age: _____			
Other pertinent family:			
Person providing intake: _____			

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
(Required by the Health Insurance Portability and Accountability Act ---- 45 CFR Parts 160 and 164)

1. I hereby authorize disclosure of information regarding my billing, condition, treatment, and prognosis to the following individual(s):

Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____

2. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

3. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

4. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.



IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ()	Work phone no.: ()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the clinic. I understand that I am financially responsible for any balance. I also authorize Autumn Oak Speech, Voice, Balance, and Hearing or insurance company to release any information required to process my claims.			
_____ Patient/Guardian signature		_____ Date	

PATIENT HIPAA CONSENT FORM / NOTICES OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name: _____

With my consent and signature, Autumn Oak Speech, Voice, Balance, and Hearing may use and disclose protected health information about me 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.
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 from me. 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 to/with third parties involved in my 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 Autumn Oak Speech, Voice, Balance, and Hearing, I may revoke this permission; however, Autumn Oak Speech, Voice, Balance, and Hearing may decline to provide further treatment to me. Autumn Oak Speech, Voice, Balance, and Hearing may also decline further treatment to me should my restrictions on the type of third-party information, in the center's opinion, impede medical care of me.

I have the right to review the Notice of Privacy Practice Manual of Autumn Oak Speech, Voice, Balance, and Hearing. Autumn Oak Speech, Voice, Balance, and Hearing 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 my care.

I have the right to request that Autumn Oak Speech, Voice, Balance, and Hearing restrict how it uses or discloses my health information. However, as stated previously, Autumn Oak Speech, Voice, Balance, and Hearing is not required to agree to my restrictions. If Autumn Oak Speech, Voice, Balance, and Hearing accepts my restrictions, Autumn Oak Speech, Voice, Balance, and Hearing 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, Autumn Oak Speech, Voice, Balance, and Hearing, in their sole discretion, may decline further treatment for me.

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

Patient/Guardian Signature

Date

PATIENT MEDICAL & SPEECH HISTORY

(Please Print)

Patient's Name: _____ Date: _____

What is your primary reason for visiting today?

- I have difficulty speaking
- I choke/cough when I swallow food/drink
- I have difficulty remembering things
- My voice is hoarse
- Other reasons: _____

What do you think may have caused the problem? _____

Has the problem changed since it was first noticed? _____

Have you seen any other speech pathologist? If yes, when/ where? _____

Have you seen any other specialists (physicians, neurologists, psychologists etc.)? If yes, indicate the type of specialist, the date when you were seen, and the diagnosis:

What languages do you speak? _____

Who resides at home with you? _____

Family medical history: _____

List any medications prescribed for you: _____

Have you had or currently have any of the following:

- High Blood Pressure
- Heart Disease
- Stroke
- Tinnitus



- | | | | |
|--|---|---------------------------------------|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Noise Exposure |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Head Trauma | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> COVID-19 |
| <input type="checkbox"/> Dizziness/Vertigo | <input type="checkbox"/> Balance Issues | <input type="checkbox"/> Falls | <input type="checkbox"/> Other |
| <input type="checkbox"/> Autism | | | |

List any major surgeries and date: _____

List any major accidents and date: _____

How would you describe your swallowing abilities? _____

How would you describe your social/daily life? _____

Functional Activities Questionnaire

Ask informant to rate patient's ability using the following scoring system:

0	1	2	3
Normal *OR* Never did it before, but could/ can do it (e.g. spouse usually does it)	Does by self But has difficulty *OR* Never did it, but would have difficulty	Requires assistance	Dependent/ Someone else does it

Activity	Rating
1. Writing checks, paying bills, balancing checkbook	0 1 2 3
2. Assembling tax records, business affairs, or papers	0 1 2 3
3. Shopping alone for clothes, household necessities, or groceries	0 1 2 3
4. Playing a game of skill, working on a hobby	0 1 2 3
5. Heating water, making a cup of coffee, turning off stove after use	0 1 2 3
6. Preparing a balanced meal	0 1 2 3
7. Keeping track of current events	0 1 2 3
8. Paying attention to, understanding, discussing TV, book, magazine	0 1 2 3
9. Remembering appointments, family occasions, holidays, medications	0 1 2 3



10. Traveling out of neighborhood, driving, arranging to take buses	0	1	2	3
11. Participating in social activities	0	1	2	3
12. Calling someone on the telephone	0	1	2	3
13. Participating in conversations	0	1	2	3
14. Asking for help/ assistance	0	1	2	3
15. Communicates wants and needs	0	1	2	3
16. Advocating for care	0	1	2	3
17. Answering questions at a medical appointment	0	1	2	3

TOTAL SCORE: _____

Pfeffer, R.I., Kurosaki, T.T., Harrah, C.H. Jr., Chance, J.M., & Filos, S. (1982). Measurement of functional activities in older adults in the community. Journal of Gerontology, 37(3), 323-329. Reprinted with permission of Oxford University Press.

OUR OFFICE POLICIES

(Please Print)

Patient's Name: _____ Date: _____

Thank you for choosing us as your provider. At Autumn Oak Speech, Voice, Balance, and Hearing, we recommend testing that is based off best practices and not what your insurance policy may or may not cover. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial and office policies, which we require you to read and sign prior to any treatment.

Insurance Benefits

You will be given an **ESTIMATED** amount due before services are rendered. The insurance plans accepted in our office have different percentages, deductibles, maximums, services covered, and varying fees that the plans will allow. Therefore, we cannot guarantee the exact amount of payments from insurance plans. Although we verify coverage, only an estimated amount is provided to the clinic.

We may accept assignment of benefits as a service to you. This means we will file a claim with the insurance company for their estimated portion of coverage. However, we are unable to bill your insurance unless you provide us with your current insurance information. The balance is your responsibility whether your insurance pays or not. Any variations or non-covered services are the patient's responsibility if services are rendered at the date of service. If we do accept the assignment of benefits from your insurance company, we require that your account is paid in full within 60 days of service.

Referrals

If a referral is required by your insurance carrier it is your responsibility to obtain the referral prior to your appointment.

Financial Policies

- Full payment is due at the time of service.
- There is a \$45 service charge for all returned checks. If a check is returned, you will be notified as soon as possible.
- If your account goes over 90 days past due, it will be turned over to our collection agency.

Late or Missed Appointments



For our providers to see patients in a timely manner please arrive promptly for your appointment. As a courtesy our office will call or text all our patients the day before your appointment for confirmation.

If there is non-compliance of attendance (e.g., excessive cancellations monthly by our calculations) then all future appointments will be cancelled. If the patient misses 2 consecutive appointments with our office, any future appointments will be cancelled. In addition, a \$45 charge will be made for each additional canceled or missed appointment unless a 24-hour notice is given. (Initials: _____).

Medical Records

Should you need a copy of the medical records, please allow 7-10 business days for completion. If records are being sent to another provider, a signed Consent to Release of Information form must be completed.

Use of Artificial Intelligence (AI)

Artificial intelligence (AI) may be lawfully utilized to assist in the recording, transcription, and documentation of patient care interactions, provided such use complies with applicable privacy legislation, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA). AI-driven systems can facilitate the accurate capture of clinical conversations, generate real-time transcripts, and automate the integration of pertinent details into electronic health records (EHRs), thereby enhancing both the accuracy and efficiency of clinical documentation. The deployment of such technologies are accompanied by appropriate consent protocols, robust data encryption, and secure storage practices to ensure the confidentiality, integrity, and lawful handling of protected health information (PHI).

Subpoena Policy

Autumn Oak Speech, Voice, Balance, and Hearing is a small business which survives on patient care and our regular daily operations. Due to the influx of subpoenas received, especially those served with less than a 24-hour notice, the following policy will be implemented immediately 11/29/2022:

If a provider or staff is subpoenaed to court for your custody case or any case requiring loss of scheduled patient care, the following charges will ensue: **\$300 charge per hour including travel time**

If a provider or staff is served with a 24-hour or less subpoena notice, the following charges will ensue: **\$400 charge per hour including travel time**

Autumn Oak Speech, Voice, Balance, and Hearing has the right to protect and maintain our patient care and the staff who are employed. Your signature below indicates that you are aware, informed, and responsible for these charges.

Patient/Guardian Signature

Date