Speech Avenues Therapy Co is a company that provides speech and language services in Brevard County, Florida. We are currently contracted in network with Medicaid, Staywell, Cigna, CMS Wellcare, UHC and out-of-network providers of private insurances.

Please sign and return:

● Case history

● Billing agreement

● Cancellation policy

● Authorization release form

● HIPAA signature page

Once these forms are completed and signed, return them to Speech Avenues Therapy Co. via either mail, email, or fax to numbers below.

In addition, we will need a prescription from your PRIMARY CARE PHYSICIAN for

SPEECH THERAPY EVALUATION AND TREATMENT

Adult Case History Form

Name:  Date of Birth: Sex: M F

Address: Daytime Phone 

Occupation:  Education: 

Name of nearest relative: Cell Phone: 

Address: 

E-mail:  

Primary Ins Co: Member # 

Secondary Ins Co:  Member # 

Indicate if private pay: 

Doctor’s Name:  Doctor’s Phone: 

Is there a language other than English spoken in the home? Yes  No

If yes, list language?  What is the primary language used? 

**Speech/Language and Hearing History**

Please describe present speech/language/hearing problem:



Has the speech/language/hearing problem improved or expected to improve? (please explain):



What conditions seem to make the problem better or worse? (please explain)



How does speech/language/hearing affect your job and your communication with others?



Have you ever had a speech evaluation/screening?  Yes  No

If yes, where, and when? 

What were you told? 

Have you ever had a hearing evaluation/screening?  Yes  No (Please fax copy)

If yes, where, and when? 

What were you told?



Have you ever had speech therapy?  Yes

If yes, where, and when?



What was he/she working on? 

Have you received any other evaluation or therapy (physical therapy, counseling, occupational therapy, vision, etc.)?  Yes

If yes, please describe

Are you aware of, or frustrated by, any speech/language difficulties? 

What do you see as your biggest obstacles most difficult problem in your daily living?



**Medical History**

**Have you had any of the following?**

**adenoidectomy**

**encephalitis**

**seizures**

**cochlear implants (date)**

**allergies**

**flu**

**sinusitis**

**breathing difficulties**

**head injury**

**apnea**

**vision problems**

**hearing problems**

**chicken pox**

**high fevers**

**frequent colds**

**stroke- Date:  Type:**

**meningitis- Date: Type: **

**other **

**Other serious injury/surgery: **

**Are you currently (or recently) under a physician’s care? Yes No**

**Have you been diagnosed with a pre-existing condition? Yes No**

**If yes, what was the diagnosis? **

**Please list any medications you take regularly:**

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**Current Speech-Language-Hearing**

**Traumatic Brain Injury**

**Date of injury: **

**Cause of injury (accident, stroke, disease): **

**Length of unconsciousness (if any): **

**Describe paralysis (if any): **

**Any complaints of: Dizziness: Yes No**

**Faintness: Yes No**

**Headaches: Yes No**

**Describe any visual or hearing problems? **

**Please describe any other medical background related to the problem:**

****

**Communication**

**Please describe the present concern: **

**Any previous speech and language assessment: Yes No**

**If yes, When? **

**Where? **

**By whom? **

**Diagnosis: **

**Please attach or have sent copies of any relevant reports from other agencies.**

**What was your (the client’s) speech and/or language like at the onset of the problem?**

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**How has it changed? **

**Check the following according to your (the client's) present abilities (i.e., what you can do):**

**Indicate meaning by gesture**

**Say short sentences**

**Repeat words spoken by others**

**Tell time**

**Follow requests & understand directions**

**Write name without assistance**

**Use one or a few words over and over**

**Follow radio or television speech**

**Write sentences, letters**

**Use some words spontaneously**

**Read signs with understanding**

**Do simple arithmetic**

**Say short phrases**

**Read newspapers, magazines**

**Handle money, make change**

**Swallowing**

**Has your (the client's) communication difficulty affected your social life? Yes No**

**If so, explain: **

**Has your (the client’s) communication difficulty affected your job/professional life?**

**Yes No**

**If so, explain:  Other languages spoken: **

**Handedness before injury:  handedness after: **

**Since the injury, describe any changes in mood, personality, ability to care for self, etc.: **

**Describe involvement in group activities (e.g., bowling leagues, church fellowships, etc.):**

****

**What do you hope to gain from treatment?**

****

**Is there any additional information that would help us better understand the problem?**

****

**Additional Comments:**

****

**Billing Agreement**

This Agreement explains how you will be billed for speech-language pathology evaluations and

therapy services. Please review this agreement carefully, sign and keep a copy for future

reference.

**Calculation of Fees:** Our fees are based on the insurance guidelines and procedures we are contracted to provide; in addition to, cost of operations to provide services. Brief conferences between sessions, as well as brief telephone conferences, are considered a part of the regular intervention program, and no additional charges will be made.

Conferences with parents, attorneys, physicians, tutors, or teachers that exceed 10 minutes in

length will be charged directly to the client in 15 minute increments (1 unit each) at a rate of $27.50

per unit. Insurance only covers direct services administered to the client and do not cover any

extensive conferences. All provided services are billed directly to your insurance company.

**Assessment and Fees:** An initial evaluation is required for all new clients. Clients are required to

participate in a re-evaluation every 6 months to determine if services are continued to be

necessary. All evaluation reports must be signed by the patient’s primary care physician. If any

report is faxed to a physician and not returned within 3-5 business days, the parent will be requested to help obtain the report from that physician. Speech Pathways of Brevard clinicians reserve the right to remove a patient from their schedule should a signed report not be obtained within two weeks from submission. Patient will be put back on our list to be available to another clinician.

**Speech Therapy Fees:** Speech pathology sessions include direct treatment time and time at the

end of each session for parent consultation and documentation. It is important to us that we have

time to speak with clients, parents and/or caregivers to explain treatment, share progress and

clarify homework. We ask that you assist us in being considerate to the client scheduled after you.

**Responsibility of Payment of Fees:** Professional services are charged to the client and filed

directly with the insurance company. The client is responsible for any co-payment amounts,

deductibles or co-insurance amounts at the time of each service. According to the insurance

company stipulations, once insurance benefits are exhausted, the patient will revert to fee-for service

status and will be billed at our standard rate of $110/hour. If insurance benefits are

denied for any reason, the client will be responsible for any evaluation fees and our standard rate

of $110/hour. Clients are personally responsible for the payment of bills should insurance deny

payment, in which case, payments are due at the time of service. It is the responsibility of the

caregiver to know the amount to be paid at the time of service.

**Payment Procedures:**

Payments should be made at the time of service rendered by check, credit card or money order made

to Speech Avenues Therapy Co. A superbill or invoice will be provided at the time of service.

Payments by check or money order can be sent to:

Speech Avenues Therapy Co

107 Longwood Avenue

Rockledge, FL 32955.

A $25 fee will be charged for all returned checks.

**Timing of appointments:** Home health appointments must allow the therapist a 30 minute window

for arrival times. We will make a conscious effort to arrive at the designated time however, due to

traffic, weather and unforeseen circumstances we cannot commit to an arrival time. If a parent or

legal guardian cannot be present for therapy, then an adult over the age of 18 must be

present for all sessions. That individual MUST remain on site for the entirety of the therapy

session. He/she may NOT leave the premises for any reason no matter if therapy is taking

place in a home, school or office setting.

**Cancellation Policy:** Parent or Caregiver is required to notify Speech Pathways of Brevard 24 hours or more in advance of a cancellation. We are aware emergencies occur and ask that you do your best to notify our company of your intent to cancel and attempt to reschedule the appointment in that same week if possible. If 4 appointments are cancelled or the client is not at the agreed upon location (i.e. school, home, community meeting place) without appropriate notification, Speech Pathways of Brevard has the right to remind the client or caregiver of the cancellation policy. If 4 consecutive appointments are missed without proper notice as stated in the terms previously, Speech Pathways of Brevard reserves the right to terminate future treatment sessions and agreement to provide services.

By signing below, I, the client, parent, or legal guardian of the client, acknowledges:

I am the client or the legal guardian of the client.

I have read and accept the policies of Speech Pathways of Brevard.

I understand that I am responsible for timely payment and attendance.

** **

Client's Name (Print) Date

** **

Signature of Guardian and/or Client Date