

Dear Sir or Madam:

Welcome to Dymond Speech & Rehab., P.A.. Thank you for choosing us for your therapy services. We take great pride in how we treat our patients and the quality of our work.

I have attached “new patient” information forms & directions to our clinic for your convenience. Please have these forms filled out prior to arriving at our clinic or you will need to arrive approximately 20 minutes early. If you need to cancel this appointment for any reason, please give us at least 48 hours notice. We have an answering machine for messages after hours. If you are not able to give us ample notice, your name will go on our waiting list & we will contact you at our next available appointment opening.

If you have any questions, please feel free to email us at Dymondrehab@windstream.net or call us at (919) 777-0240.

Sincerely,

Brett Dymond
Practice Manager
Dymond Speech & Rehab., P.A.

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: _____

Patient's Signature (or parent if child under 18)

Date

Dymond Speech & Rehab., P.A.

General Biographical Data:

<u>Name</u>	<u>Age</u>	<u>Occupation</u>	<u>Education</u>	<u>Living</u>	<u>Deceased</u>
Father: _____					
Mother: _____					
Number of brothers & sisters _____			Age _____		
Number of person living in your home _____ relationship _____					
Veteran yes or no Dates of service _____					

Medical History (Please answer all that apply):

Were you recently hospitalized? _____ If yes, dates _____

When did trauma occur? (Accident, illness, operation, etc.) _____

Did you receive rehabilitation? _____ If yes, location & dates: _____

Personality changes as result of injury; if any? _____

Describe personality characteristics as your family members might report _____

Please list significant medical history with dates of onset: (stroke, Parkinson's, Dementia, etc.) _____

How would you describe your present ability to communicate and function in general: _____

Do you have any hearing issues? If so, please describe: _____

What is your main concern today? _____

How long have you been experiencing this problem? _____

Who referred you to our clinic? _____

Why are you pursuing therapy at this time? _____

Please list current medications you are taking: _____

Do you have any allergies? If yes, please describe: _____

Check the following if applicable:

- Paralysis (specify parts of body involved) _____
- plate inserted in head _____
- fainting _____
- dizziness _____
- loss of consciousness; for how long? _____
- convulsions (are they controlled)? _____
- easily tired _____
- difficulty with eating _____
- visual impairment _____
- auditory impairment _____
- headaches (severity, forms, frequency) _____
- high fever _____
- red measles _____
- Other: _____

Occupational Data:

Are you presently employed? Yes or No If yes, describe your job duties: _____

Educational History:

Highest grade completed _____ Major interest in school _____
Subject (s) most liked _____
Did you repeat a grade? Yes or No Which grade? _____ Reason? _____
Where you placed in any special education classes? _____
For which subjects _____
Extra-curricular activities _____

Social History:

Active in following organizations: _____

Hobbies and special interest: _____

Do you smoke or use tobacco in any for? Yes or No If yes, for how long? _____
Do you stutter? Yes or No If yes, how long? _____ Have you ever received therapy for stuttering? Yes or No
Do you still have periods of dysfluency? If so, describe _____

Do you have difficulty expressing yourself verbally? If so, describe _____

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 FORM

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

Financial Policy

I attest that the patient registration information is true to the best of my knowledge. 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 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. 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.

Patient's Signature (or parent if child under 18)

Date

Cancellation & No-Show Policy

1. 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.
2. You will have 3 excused absences in the course of therapy. After that no exceptions will be made except for extraordinary circumstances.
3. We expect at least 90% attendance for therapy sessions for adequate progress to be made.
4. The fee must be paid prior to being seen by a provider in this Practice

Patient's Signature (or parent if child under 18)

Date