

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 the “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](mailto:dymondrehab@windstream.net) or call us at (919) 777-0240.

Sincerely,

Brett Dymond  
Practice Manager  
Dymond Speech & Rehab., P.A.  
113 Hillcrest Drive  
Sanford, NC 27330  
Telephone: 919.777.0240  
Fax: 919.777.0499  
[Dymondrehab@windstream.net](mailto:Dymondrehab@windstream.net)

# 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: \_\_\_\_\_

**May we ask who referred you to our clinic?** \_\_\_\_\_

## **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.**

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

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**Date**

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**Staff Signature**

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**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

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

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**Date**

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**Staff Signature**

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**Date**

# 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](mailto: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.

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**Patient Name**

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**Signature**

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**Date**



# Assessment Vocabulary Checklist

Listed below are words infants and toddlers might understand or say.

**Check** the words you think your child *understands*.

**Circle** the words your child *says* when he/she speaks to you.

all	church	go bed	mine	sock
all gone	clock	go bye-bye	more	spoon
apple	coat	go night-night	more cookie	stick
arms	cold	go out	mouth	stop
baby	comb	grandma	night-night	stove
babysitter's name	cookie	grandpa	no	swing
ball	cracker	gum	nose	teeth
balloon	cup	hair	old	thank you
banana	dada/daddy	hands	on	thirsty
bear(teddy)	diaper	hat	out	tired
belly/tummy	diaper	hi	paper	toes
big	dog/doggie	horse/horsie	phone	toy
bike	don't	hot	pizza	truck
bird	done	hot dog	please	TV
book	down	huh?	potty	uh-oh
boots	drink	I	purse	under
boy	ears	in	rock	up
bug	eat	key	see	want
bunny	eat cookie	Kleenex	shhhh	wet
bye/bye-bye	eyes	legs	shirt	what
candy	fall down	little	shoe	what's that
car	feet	mama/mommy	sit/sit down	yes
cat/kitty	fingers	McDonald's/	sky	you
chair	flowers	Hardee's	sleep	yucky
cheese	girl	me	snow	
choo-choo	go	milk	so big	

**List the names of family members, friends, or pets your child says.**

\_\_\_\_\_

**List any other words your child says.**

\_\_\_\_\_