

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 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

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.

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

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

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

Dymond Speech & Rehab, P.A.

Developmental Case History:

Child's Name _____ Age: _____ Date of Birth: ___/___/___

Family/School Information: Does child live with both parents? Yes or No _____

Names and ages of siblings: _____

Name of pre-school, daycare, or school: _____

Are you thinking of using pre-school? _____

Birth History: Any complications during pregnancy? If so, please list _____

Any complications immediately following birth? If so, please list _____

Medical History: Did your child pass their hearing screening at birth? Yes or No _____

Have they had a recent screening/evaluation? Yes or No _____ Did they pass the recent screening/evaluation? Yes or No _____

Is your child current with his/her immunizations? Yes or No _____

Has your child had tubes in the past? Yes or No _____ When? _____

Do they currently have tubes? _____

How many ear infections have they had? _____

Are they being followed by an Ear, Nose, & Throat Doctor on a regular basis? Yes or No; Dr. _____

Has your child been hospitalized for any reason? _____

Circle all that apply: tonsillitis high fever meningitis seizures allergies measles croup chronic colds

Does your child have any other illness/medical problems? _____

Does your child have any vision issues? _____

Does your child have any allergies to medications or foods? _____

Developmental History:

List the age when you child began: Crawling _____ Walking _____ First Words _____ Combining words _____

Did your child babble as an infant? Yes or No _____

If you child is talking, what percent of their speech is understood? Familiar listeners- ___ % Unfamiliar listeners- ___ %

Feeding/Eating History: Did your child have any difficulties feeding after birth? If so, please

explain _____

Is your child a picky eater? Yes or No _____

When did your child stop using a bottle? _____ Pacifier? _____

Does your child have any stomach or Gastrointestinal issues? Yes or No _____

Do they have any food allergies or special diets? Yes or No _____

Play/Social Information: Does your child play appropriately with toys? Yes or No _____

Does your child engage in any odd behaviors? Yes or No _____

Does your child have difficulty attending or concentrating? Yes or No _____

Does your child have any significant problems with behavior? Yes or No _____

Sensory/Motor Development: Does your child appear awkward or clumsy? Yes or No _____

Does your child seem to dislike certain type of textures (examples does not like getting dressed, hates tags in clothes, does not like water)? Yes or No _____

Does your child shy away from trying new activities? Yes or No _____

Please list dates and places of any other evaluations (example: DEC, neurologist, occupational therapy, ECI, etc.) _____

Does your child get any services from your local school system? Yes or No _____

What services does your child get through the school system?

PT- Frequency: ___ times per _____ for ___ mins

OT- Frequency ___ times per _____ for ___ mins

ST- Frequency ___ times per _____ for ___ mins

Name: _____ Date: _____ Relationship to Child: _____