St. Lillian ACADEMY
All Children Can Soar

esp pediatric therapy services
St. Lillian Academy's therapy services partner

NEW PATIENT INFORMATION

TODAY'S DATE:_____

PATIENT'S INFORMATION

PATIENT'S NAME: _____ DOB: _____

STREET CITY: _____ ZIP: _____

CONTACT'S NAME: _____ BEST TELEPHONE: _____

DIAGNOSIS CODE: _____ REFERRING PHYSICIAN: _____

INSURED'S INFORMATION

PRIMARY: _____

INSURANCE CARRIER: BCBS ☐ UHC ☐ Cigna ☐ Aetna ☐ Coventry ☐

PHONE: (_____)_____

MEMBER ID: _____ SECONDARY MEDICAID?

NAME OF POLICY HOLDER: _____ *(Circle)* Yes No

POLICY HOLDERS DOB: _____

RELATIONSHIP TO CARDHOLDER: _____

CARDHOLDER'S SSN: _____

PATIENT'S STATUS: Single ☐ Married ☐ Other

PATIENT'S GENDER: ☐ Male ☐ Female

----------**FOR OFFICE USE ONLY**----------

RENDERING PROVIDER:

Joy Pennington, S.T.	Nicole Guest, S.T.	Kris Barrios, S.T.
Tammera Welsh, S.T.	Kathryn Medine, S.T.	Elissa McKenzie, P.T.
Tiffany Guidry, O.T.	Leigh Hermann, O.T.	

INSURANCE VERIFICATION

Date Called _____ Time _____ Spoke to _____

Effective Date _____ Deductible _____ Paid _____ Outstanding _____

Co-pay _____ Co-insurance _____% _____% Exclusions _____

# of Visits _____ Policy Year _____

INSURANCE AUTHORIZATION

YES NO Authorization # _____

Visits approved _____ Expiration _____ Ref #_____

Visits approved _____ Expiration _____ Ref #_____

Visits approved _____ Expiration _____ Ref #_____

Comments:_____

_____

_____

_____

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excellence in speech pathology LLC

Case History

Identifying and Family Information:

Form completed by: _____ Date: _____

Child's Name: _____ Birth date: _____ Sex: ☐ M ☐ F
Mother's Name: _____ Daytime Phone: _____
Address: _____ Cell Phone: _____
_____ Email: _____
_____
_____

Father's Name: _____ Daytime Phone: _____
Address: _____ Cell Phone: _____
_____ Email: _____
_____
_____

Child lives with: _____
_____

Allergies/Precautions: _____

Pediatrician: _____ Neurologist: _____
Orthopedist: _____ Ophthalmologist: _____
Gastroenterologist: _____ Other: _____

Other children in the family:

Name	Age	Sex	Grade

Service History:

Has your child had previous evaluations or screenings in the areas of:

Vision: ○Yes / No○
Hearing: ○Yes / No○
Speech Therapy: ○Yes / No○
Occupational Therapy: ○Yes / No○
Physical Therapy: ○Yes / No○

If so, please describe:

Location	Date	Results

Has your child received previous therapy?

Location	Dates	Therapist

Birth History:

Born: ☐ Full term ☐ Premature at _____ weeks gestation.
Birth weight: _____
Delivery: ☐ Vaginal delivery ☐ C-section

Were there any complications during the pregnancy or birth? ☐ Yes ☐ No

If so, please describe: _____

Medical History:

Has your child had any of the following:

- ☐ adenoidectomy
- ☐ allergies
- ☐ breathing difficulties
- ☐ chicken pox
- ☐ colds
- ☐ ear infections
  - How often? _____
- ☐ ear tubes
- ☐ encephalitis
- ☐ flu
- ☐ head injury
- ☐ high fevers
- ☐ measles
- ☐ meningitis
- ☐ mumps
- ☐ scarlet fever
- ☐ seizures
- ☐ sinusitis
- ☐ sleeping difficulties
- ☐ thumb/finger sucking habit
- ☐ tonsillectomy
- ☐ tonsillitis
- ☐ vision problems

Other serious injury: _____

_____

Surgeries: _____

_____

Medications: _____

_____

Developmental History:

Please tell the approximate age your child developed the following developmental milestones:

_____ sat alone	_____ grasped crayon/pencil	_____ babbled
_____ rolled over	_____ self feed finger foods	_____ said first words
_____ crawled	_____ used spoon	_____ put two words together
_____ pulled to stand	_____ toilet trained	_____ spoke in short sentences
_____ walked	_____ dressed self	

Does your child:

- ☐ choke on food or liquids?
- ☐ currently put toys/objects in his/her mouth?
- ☐ brush his/her teeth and/or allow brushing?

Current Speech-Language-Hearing:

Does your child:

- ☐ repeat sounds, words, or phrases over and over?
- ☐ understand what you are saying?
- ☐ retrieve/point to common objects upon request? (ball, cup, shoe)?
- ☐ follow simple directions ("Shut the door" or "Get your shoes")?
- ☐ respond correctly to yes/no questions?
- ☐ respond correctly to who/what/when/where/why questions?

Your child currently communicates using:

- ☐ body language.
- ☐ sounds (vowels, grunting).
- ☐ words (shoe, doggy, up).
- ☐ 2 to 4 word sentences.
- ☐ sentences longer than four words.
- ☐ Other: _____

Behavioral Characteristics:

- ☐ cooperative
- ☐ attentive
- ☐ willing to try new activities
- ☐ plays alone for a reasonable length of time
- ☐ separation difficulties
- ☐ easily frustrated/impulsive
- ☐ stubborn
- ☐ restless
- ☐ poor eye contact
- ☐ easily distracted/short attention
- ☐ destructive/aggressive
- ☐ withdrawn
- ☐ inappropriate behavior
- ☐ self-abusive behavior

School History:

If your child is in school, please answer the following:

Name of school and grade in school: _____

_____

Teacher's name: _____

Has your child ever repeated a grade? Which ones? _____

What are your child's strengths and/or best subjects? _____

_____

Is your child having difficulty with any subjects? Which ones? _____

_____

Is your child receiving help in any subjects? _____

_____

PATIENT FINANCIAL LIABILITY FORM

Please understand that full payment of your account/bill is considered part of your treatment and is required for services rendered. Although we make every effort to obtain accurate information from the insurance carrier, verification of benefits is not a guarantee that an insurance carrier will pay a claim. The insurance carrier makes final determination based upon the plan's level of coverage and associated policies, upon receiving the claim. Denied claims become the responsibility of the patient. In the event that a patient does not have insurance and is paying by cash, we offer a 25% discount off of our billable amount. This office accepts Visa, MasterCard, checks or cash. Returned checks are subject to additional fees. All unpaid accounts are sent to collection after payment is not made in a reasonable time period and may adversely affect your credit. Non-emergent medical services can be denied for unpaid accounts.

INSURANCE IS ACCEPTED UNDER THE FOLLOWING CONDITIONS:
All copayments are due to Excellence In Speech Pathology, L.L.C. at the time of service. Patient agrees to pay all deductibles, coinsurance and services deemed "patient responsibility" as identified by the insurance carrier. Deductibles, coinsurance, and patient portions are billed monthly on receipt of the patient's insurance statement from the insurance carrier regarding your patient claim. YOU, the patient, are responsible to render payment once billed for the remainder. Patients are fully responsible for obtaining any necessary referral from another physician before the appointment time. Claim payments denied due to lack of referral become the patient's responsibility. Verifications and authorizations for services provided by the insurance company are not a guarantee that the services will be paid. Therefore, it will be the patient's responsibility to pay any services denied by the insurance company. I have read the above information and agree to the terms contained therein.

_____
Patient's PRINTED Name

_____
Responsible Party's PRINTED Name

_____
Responsible Party's Signature

_____
Date

CANCELLATION, NO SHOW AND ILLNESS POLICY

We have a waiting list for new patients and a full schedule of ongoing patient care appointments. To maximize efficient clinic operation, we make every effort to minimize last minute client cancellations. Out of respect for our professional staff and for patients waiting to obtain therapy services we have established these policies effective .

CANCELLATION

We ask for a 24-hour notice of cancellation of your scheduled appointment. Failure to notify us in advance will result in a $40 charge that is payable at your next scheduled appointment. We recognize that emergencies do occur and will determine when and if fees will be waived.

NO-SHOW OR SHORT NOTICE

Any no-show or short notice change of scheduled appointments will be charged 40$ per occurrence. This fee cannot be billed to your insurance. This fee will be due at the time of your next appointment.

ILLNESS

Please do not come to your appointment if you are sick. We make every effort to provide a clean healthy environment by not exposing staff and patients to infectious conditions. Anticipate your condition and plan 24-hours in advance of your appointment. If your child is running fever or has vomiting or diarrhea, we ask that you cancel your appointment.
Thank you for helping us to be efficient in our operation and considerate of others.

FINANCIAL POLICY
We have found that early communication with our patients regarding our financial policy provides the best service possible. Please review these policies and call us if you have any questions.

PRIVATE INSURANCE
Insurance verification and or authorization will be obtained prior to assessments and evaluations. Our billing agent is pleased to directly bill your insurance company after your insurance coverage has been verified. If ESP is not in network or a preferred provider, the patient will be responsible for payment at the time service is rendered. Co-payments and annual deductibles will be collected at the time of service unless you have made other arrangements with our administrative assistant. Each benefit package is unique and each patient is advised to review their benefit statements for coverage details. Most insurance companies pay a percentage of your bill. ***It is the responsibility of the patient to remit any amount not covered by insurance.*** All questions regarding billing and invoices received should be addressed with Accurate Medical Billing at (225) 928-5449.

PRIVATE PAY
Full payment is expected when services are rendered. We accept cash, personal checks and credit cards.

Waiting areas are available, as well as a resource area for patients and families waiting for their child. Parents will not be allowed to attend therapy sessions during St. Lillian Academy School, school hours (8:15-2:45) unless accompanied by a therapist.

ACKNOWLEDGEMENT AND AUTHORIZATION

I have read and understand the Financial Policy. I authorize my insurance benefits to be paid directly to Excellence In Speech Pathology, LLC (ESP). I am financially responsible for any balance not covered by insurance. I authorize the release of any information needed in the processing of my claim.

_____
Signature (parent or guardian if patient is a minor)

_____
Date

I have read and understand the Cancellation, No-Show, Short Notice and Illness Policy and understand that I will be responsible to pay a $40.00 fee for no-show or short notice change of scheduled appointments and that the fee will be due at the time of my next appointment.

_____
Signature (parent or guardian if patient is a minor)

_____
Date

I have read and understand the ESP Therapy Privacy Practices

_____
Signature (parent or guardian if patient is a minor)

_____
Date

Therapy Fees

Speech Language Evaluations

- Reading/Language $175.00
- Articulation $150.00
- Preschool Language $150.00
- Fluency $150.00
- Voice.....$150.00
- Occupational Therapy Evaluation $150.00
- Feeding Evaluation.....$150.00
- Physical Therapy Evaluation.....$150.00

Direct Therapy Services

- Covered $90.00/hr
- Out of Pocket..... $80.00/hr