Professional Speech & Language Therapy, Inc.
Speech Therapy Services
1514 E. Cleveland Avenue, STE 200
East Point, GA 30344
Phone: (678) 608-9601 ● Fax: 1 (800) 420-4398

PATIENT INTAKE INFORMATION

Please Print

Patient:

Last Name _____ First _____ Middle_____

Male Female DOB: _____

Address: Street 1_____ Street 2 _____

City _____ State_____ Zip_____

Phone: Home _____ Cell _____

Email: _____

If patient is not a minor:
Preferred contact manner: (circle all that apply) Home Cell Email
Okay to leave a message: (circle all that apply) Home Cell Email

Medical Details:

Primary Diagnosis: _____Onset Date: _____

Secondary Diagnosis: _____Onset Date: _____

Referring Physician: _____ NPI _____

Practice Name: _____

Street 1_____ Street 2 _____

City _____ State_____ Zip_____

Phone: _____ _____ Fax _____ _____

Pertinent Medical Information (allergies, medications, etc.) _____

_____

Financially Responsible Person (Insured Parents or Guardians):

Last Name _____ First _____ Middle_____

Male Female DOB: _____

Relationship to Patient: _____

Phone: Home _____ Cell _____

Email: _____

Preferred contact manner: (circle all that apply) Home Cell Email

Okay to leave a message: (circle all that apply) Home Cell Email

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Insured's Employer:

Company Name: _____

Street 1 _____ Street 2 _____

City _____ State_____ Zip_____

Phone_____ Email_____

Patient's School:

School Name: _____

School City _____ Attends: Full Time Part Time

Attestation Regarding IEP/IFSP for Outpatient Therapy Services

Certain patients with Medicaid coverage that attend a school may have an **Individualized Educational Plan** (IEP) or an **Individualized Family Service Plan** (IFSP) initiated by the school. We are obligated to submit a copy of this document.

☐ **By initialing this box the undersigned confirms that the patient does NOT have an IEP or an IFSP at this time.**

____/____/____ **By entering the expiration date in this box the undersigned confirms that the patient does have an IEP or an IFSP and agrees to provide a copy to Professional Speech & Language Therapy, Inc.**

The undersigned authorizes Professional Speech & Language Therapy, Inc., to share patient's medical and treatment information with the named school system.

Insurance:

Claim submission order will be Private first. Private carriers do not include Medicare or Medicaid.

Primary Private Carrier: _____

Insured's Name: _____ Insured's DOB: _____ Group # _____ ID # _____ Co-Pay $ _____

☐ **By initialing this box the undersigned confirms that the patient has no primary private insurance coverage at this time.**

Secondary Private Carrier: _____

Insured's Name: _____

Insured's DOB: _____ Group # _____ ID # _____ Co-Pay $ _____

☐ **By initialing this box the undersigned confirms that the patient has no secondary private insurance coverage at this time.**

PATIENT IS AN AUTHORIZED MEDICAID RECIEPIENT: Amerigroup Well Care Peach Care Peach State

Medicaid ID Number _____ Group ID Number _____

Circle or fill in patient's **Medicaid Type**: Deeming Waver SSI Foster Child _____

PATIENT IS AN AUTHORIZED MEDICARE RECIEPIENT:

Medicare Number _____

☐ **By initialing this box the undersigned confirms that the patient has no MEDICAID or MEDICARE insurance coverage at this time.**

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Emergency Contact Information:

Primary Contact Name: _____ Contact Phone #: _____

Alternate Phone #: _____

Secondary Contact Name: _____ Contact Phone #: _____

Alternate Phone #: _____

In case of an emergency, the undersigned Professional Speech and Language Therapy, Inc. to seek treatment for the patient until such time that the undersigned or another legal guardian can be present.

Other Therapist Contact Information:

Professional Speech & Language Therapy Inc., is hereby authorized to share and exchange medical and treatment information regarding the patient with the below named individuals and companies who may also render therapy services to the patient.

Name _____ OT PT SLP Other_____

Company Name: _____ Address 1: _____

Address 2: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Name _____ OT PT SLP Other_____

Company Name: _____ Address 1: _____

Address 2: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Name _____ OT PT SLP Other_____

Company Name: _____ Address 1: _____

Address 2: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

_____ _____

Signature: Patient or Agent/Guardian/Representative **Date**

_____ _____

Printed name of Patient's Agent/Guardian/Representative **Agent/Guardian/Representative Relationship to Patient**