Simone Hüls, Ph.D., CCC-SLP

Licensed Speech-Language Pathologist (CA SP 25805)
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Legal Name: ___________________________________ Preferred Name: ___________________________

DOB: _______________________ Gender ___________________ Pronouns _________________________

You may be used to filling out forms with the options of Male or Female. I am striving to create an inclusive practice that is supportive and affirming to individuals of all gender identities and presentations. Therefore, I am asking you to complete these questions with the way you identify, regardless of how others view/categorize you. If you are uncomfortable completing this information, please feel free to leave it blank and we can discuss it later.

Address: __________________________________City________________________ State______________

Zip Code: ____________________E-Mail:____

Phone 1: ___________________________________ Phone 2:_____________________________________

Primary Physician: ______________________________________Phone: ___________________________

Referring Physician (if different): _____________________________________

How did you hear about me? ____

Previous speech therapy evaluations/treatment (list): ____

Have you received ANY home health services this year including nursing? Yes_______ No________

If yes, with which agency?___________________________ When were you discharged?______________

Are you currently receiving home health therapy? Yes____ No ____ If yes, which agency are you receiving services from? _________________________ When do you anticipate discharge? ___________

*Please be advised if you are receiving home health services, insurance will **NOT** cover outpatient services at the same time. If you do not disclose information regarding home health services and your insurance does **NOT** pay, **YOU WILL BE RESPONSIBLE FOR THE BALANCE.**

Chief Complaint:

____

____

____

____

____

Who noted present problem? ____

When? ____

How do your friends and family react to the problem? ______________________________________

____

____

Has there been any significant change in last six months? _____ If so, what? ________________________

____

____

MEDICAL HISTORY

Please check if you have had any of the following and if so, when:

Seizures _____	High fevers_____	Measles_____	Mumps _____
Chicken Pox_____	Whooping Cough_____	Croup ____	Pneumonia _____
Tonsillitis____	Meningitis____	Encephalitis_____	Thyroid_____
Rheumatic Fever _____	Tuberculosis_____	Sinusitis_____	Chronic Colds____
Enlarged Glands_____	Asthma______	CHF_____	Cancer _____
GERD____	Vocal Chord Paralysis_____	COPD_____	

Explain any checked items here: ____

____

____

Are immunizations current? Yes_______ No_________

Family Medical History relevant to current complaint:

____

____

Current General Health:

When was your last physical exam? ____

Allergies? Yes______ No_______ If Yes, describe____

____

Food allergies:

____

Any other serious or recurrent illnesses? ____

Any operations? Yes ____ NO____ If Yes, describe____

____

Any accidents involving head and/or neck trauma or loss of consciousness? ________________________

____

Any medications? If Yes, please list along with dosage and # taken per day (printed list acceptable)

____

____

Vision problems? Yes ____No____ If Yes, Past_______ and/or Current_______

Hearing difficulties: Yes_____ No_____ Hearing aids: Yes____ No______

Dental problems? Yes_____ No_____If Yes, please explain: _____________________________________

Dentures: Yes_____ No______ Do your dentures fit well and are comfortable? _____________________

OTHER

What goals would you like to achieve with therapy? ____

____

Anything else you would like us to know? ____

____

CONTACT INFORMATION

At times, I may need to contact you for appointment reminders or other concerns. Please complete only the items below that you authorize as a method of contact. Note: **Only one phone number and one e-mail address are required.**

Home Phone: ________________________________ Ok to leave message: Yes______ No_______

Cell Phone: _________________________ Ok to leave message: Yes_______ No_______

Email: ___________________________________ Ok to email message: Yes______ No_______

Emergency Contact: ______________________________ Phone: _________________________________

Relationship to Client: ____

INSURANCE/PAYMENT INFORMATION

Primary Insured:__________________________ DOB: ______________ SS#_________________________

Primary Insurance Carrier: ________________________ Phone Number: ___________________________

Billing/Claim Address: _________________________City: ____________________ State:_____________

ID #: ________________________________ Group #: ______________________________

Secondary Insurance: ___________________________ Policyholder Name: _________________________

Phone Number: __________________________ Billing/Claim Address: ______________________________

City:___________________________ State:____________ ID#___________________________________

Group #: __________________________________

As a courtesy, I will verify your insurance benefits. However due to inconsistent information provided by the insurance companies, verification is NOT a guarantee of payment. Payment is ultimately the responsibility of the patient/guarantor.

Assignment of Benefits (Insurance patients only):

I____________________________________, authorize the release of any payment and medical information necessary to process myself or my family member's insurance claim and related claims. I hereby authorize payment directly to Simone Hüls, PhD of the insurance benefits otherwise payable to me for all professional services.

Signature of Policyholder: ____Date:_______________

PARTY RESPONSIBLE FOR PAYMENT

Name: ____________________________________ DOB: _________________ SSN: _________________

Address ______________________________________ Phone: ___________________________________

Employer Name:_____________________________________Phone:_______________________________

Employer Address: ____

______I have read and understand the payment policy.

PHOTOCOPY AUTHORIZATION

I permit a photocopy of this consent form as if it were an original executed consent.

Name of Patient (Printed): ________________________________ Date: ______________________

By signing below, you are attesting to the accuracy of the above statements including all consents and authorizations implied therein. A copy of this agreement is available upon request.

Patient Signature (if over 18 years or emancipated): _____________________________ Date__________

Thanks so much for completing this form!