LET'S TALK SPEECH & LANGUAGE THERAPY SERVICES, LLC

Adult Case History Form

Client Name:____Age:_________Date:_________________

Date of Birth: ____Gender: ◯ Male ◯ Female

Address: ____Phone: ________________________________

City:____________________________________ State:____________ Zip Code:_________________________

Completed by:____________________________________ Relationship to Client:________________________

Referred by:____Phone:___________________________

Emergency Contact:____Phone:_____________________________

Address:____

Language(s) spoken:_________________________________ Primary Language:__________________________

Single______ Married_______ Widowed______ Divorced______

Is there family history of speech-language disorders?:____

____

Medical Information

Current health status (check one): ◯ Excellent ◯ Good ◯ Fair ◯ Poor

Date of most recent physical or doctor's visit:___ ______________________________

Current Physician's name: ____________________________________Phone: _______________________ _____

Physician's address: ____

Previous history of illnesses (list illness and age of occurrence):

____

____

Allergies:____

Medications:____

Surgeries/Accidents:

1.____________________________Hospital/Doctor:______________________________Mo/Year:___________

2.____________________________Hospital/Doctor:______________________________Mo/Year:___________

3.____________________________Hospital/Doctor:______________________________Mo/Year:___________

Medical Diagnosis:

1.__________________________Facility/Professional:____________________________Mo/Year:___________

2.__________________________Facility/Professional:____________________________Mo/Year:___________

3.__________________________Facility/Professional:____________________________Mo/Year:___________

Hearing/Vision

Passed hearing screening/evaluation? ◯ yes ◯ no Date of last hearing screening/evaluation:___________

Location of last hearing screening or evaluation:____

Do you wear hearing aids? ◯ yes ◯ no ◯ right ear ◯ left ear

Do you wear glasses? ◯ yes ◯ no

Any hearing or vision concerns/issues?:____

Education/Work

Highest Degree Completed:_________________________________

Academic difficulties? (Please Specify) ____

Are you currently employed? ◯ yes ◯ no

Job Title:______________________________________ Company:_____________________________________

Concerns with work performance? (Please Specify) ____

____

Previous Therapy/Evaluations

Have you previously received a speech-language evaluation? ◯ Yes ◯ No

Date of evaluation:______________________ Location of evaluation:_________________________________

Have you previously received speech-language therapy services? ◯ Yes ◯ No

Location:__________________ Start Date (Month/Year):_____________ End Date (Month/Year):__________

Location:__________________ Start Date (Month/Year):_____________ End Date (Month/Year):__________

Have you received any of the following types of evaluations and/or therapy services (check all that apply):

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___Occupational Therapy ___Physical Therapy ___Neurology ___Neuropsychology ___Psychology

Other:____

Please specify **dates and locations** of therapy services or evaluations:____________________________________

____

____

Sign:____**Date:**____________________________

120 W. Center St., Unit 2, W. Bridgewater, MA 02379 phone (508) 230-8181 fax (508) 230-8182
www.ltspeech.com

INSURANCE FORM

Prior to your first visit at Let's Talk Speech & Language Therapy Services, we request that you contact your insurance company to determine eligibility for speech-language therapy services, and obtain a referral if necessary. Failure to do so may result in the patient being responsible for payment of services due to insurance denials.

Please call the member services number on the back of your insurance card and ask what your benefits are for outpatient speech-language therapy services.

- If speech/language concerns are due to a congenital issue that you or your child have *always* had and/or is related to development, services would be habilitative.
- If speech/language concerns are due to a *loss of skills* that you or your child have experienced due to a major accident/illness/injury, services would be considered rehabilitative.

Record the following information:

1. Is Let's Talk: In-network ____ Out-of-network _____ (**NPI #1780952473**)
   a. If out-of-network, do you have out-of-network benefits: Yes____ No____
2. Do you need a referral for an evaluation: Yes ______ No ______
3. Do you need a referral for therapy services: Yes_____ No______
   a. If Yes, record the date that you called PCP for referral:________________
4. Do you need an authorization for therapy services: Yes____ No______
5. Do you have a deductible: Yes____ No_____
   a. If Yes, what is the amount:______________________________________
6. Do you have a coinsurance or copay: Yes____ No_____
   a. If Yes, what is the amount:______________________________________
7. Is your plan based on a plan year or calendar year:________________________
8. How many visits do you get per plan/calendar year:_______________________
9. Are there exclusions for your plan: Yes____ No______
   a. If Yes, what are the exclusions:__________________________________
   ____
   ____
10. Name of the representative that you spoke with:__________________________

X________________________________ ______________
Patient/Parent/Guardian Signature **Date**