TOTH Speech Services

20283 St Rd 7, Suite 102
Boca Raton, FL 33498
+1-561-400-1931

Intake Form

PATIENT'S NAME: _____

DATE OF BIRTH: ___/___ /_____

HOME ADDRESS:_____

CITY, STATE, ZIP _____

PHYSICIAN NAME: _____

ADDRESS:_____

CITY, STATE, ZIP _____

PHONE # _____

Emergency Contacts:

NAME: _____

ADDRESS:_____

CITY, STATE, ZIP _____

PHONE # _____ RELATIONSHIP:_____

NAME: _____

ADDRESS:_____

CITY, STATE, ZIP _____

PHONE # _____ RELATIONSHIP:_____

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Background Information:

Do you have any concerns regarding speech? ☐YES ☐NO ☐N/A

If you answered yes, please describe your concerns:

_____

Do you have any concerns regarding language? ☐YES ☐NO ☐N/A

If you answered yes, please describe your concerns:

_____

Do you have any concerns regarding swallowing? ☐YES ☐NO ☐N/A

If you answered yes, please describe your concerns:

_____

When were the above concerns first noticed? _____

Has the issue changed (worsened/resolved) since it was first noticed. If so, please explain.

_____

_____

Has a specialist seen the patient regarding any of the above concerns? ☐YES ☐NO

Date of last visit: ___/___ /_____

If you answered yes, please provide any conclusion or recommendations:

_____

_____

May we obtain copies of previious evaluations and/or discharge reports? ☐YES ☐NO

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Social History

Patient's Current Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Separated/Not Divorced ☐ Widowed ☐ Domestic Partnership

SPOUSE'S NAME (if applicable):_____

ADDRESS:_____

CITY, STATE, ZIP _____

PHONE # _____

Do you have children? ☐ YES ☐ NO

Child's Name: Age: Gender:

_____

_____

_____

Highest grade, diploma or degree earned: _____

Please describe current or past occupation/employer (leave blank if student)

_____

_____

_____

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Please describe any hobbies/interests:

_____

_____

What is the best way you learn new things: Written Instruction ☐ Verbal Instruction ☐

Hands on learning ☐ Other ☐ If other, please describe:

_____

_____

Medical History:

Do you currently have any medical diagnoses? ☐ YES ☐ NO

If you answered yes, please describe what they are:

_____

_____

Are you currently taking any medication? ☐ YES ☐ NO

If you answered yes, please list name of medication and dosage amounts:

_____

_____

Do you have any known allergies? ☐ YES ☐ NO

If you answered yes, please list:

_____

_____

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Has the patient's vision been tested? ☐ YES ☐ NO

Date of last visit: ___/___ /_____

If you answered yes, please provide Opthamologist's name and results:

_____

_____

Has the patient's hearing been tested? ☐ YES ☐ NO

Date of last visit: ___/___ /_____

If you answered yes, please provide Audiologist's name and results:

_____

_____

Do you use English as a second language? ☐ YES ☐ NO

If you answered yes, what is your native language:

_____

Speech and Language Skills:

Do you have difficulty expressing your need and wants? ☐ YES ☐ NO

If you answered yes, please explain:

_____

_____

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Do others find it difficult to understand you? ☐ YES ☐ NO

If you answered yes, please explain:

_____

_____

Do you find it difficult to understand others? ☐ YES ☐ NO

If you answered yes, please explain:

_____

_____

Do you have short term and/or long term memory difficulties? ☐ YES ☐ NO

If you answered yes, please explain:

_____

_____

Do you have difficulty with word finding? ☐ YES ☐ NO

If you answered yes, please explain:

_____

_____

Do you find it difficulty with reading and/or writing? ☐ YES ☐ NO

If you answered yes, please explain:

_____

_____

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Has there been any changes with your voice? (i.e. hoarse, breathy, loss)? ☐ YES ☐ NO

If you answered yes, please explain:

_____

_____

Speech and Language Skills:

Please check if you have difficulty with any of the following:

☐ Chewing food	☐ Drooling	☐ Moving food to back of mouth
☐ Increased meal times	☐ Watery eyes when eating	☐ Coughing
☐ Managing liquids	☐ Clearing food from mouth	☐ Choking

Other: _____

Are you currently on a modified dood and/or liquid diet? ☐ YES ☐ NO ☐ N/A

If you answered yes, please explain:

_____

_____

Are there any food/liquid textures that you avoid? ☐ YES ☐ NO ☐ N/A

If you answered yes, please explain:

_____

_____

Do you currently wear dentures? ☐ YES ☐ NO ☐ N/A

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Activities of Daily Living:

Please check if you require assistance with any of the following:

◻ Dressing	◻ Toileting	◻ Cooking	◻ Eating
◻ Telling time	◻ Hygiene	◻ Housekeeping	◻ Driving
◻ Money management	◻ Tracking appoint-ments	◻ Shopping	

Other: _____

Therapy Goals:

What are your current speech/language related goals?

_____

_____

What are your prefered times available for therapy?

_____

_____

Please provide any additional information that may be helpful to the evaluation/treatment process:

_____

_____

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The above information is true and completed to the best of my knowledge:

Patient Signature:_____ DATE: ___/___/_____

Print Name: _____

If other than patient, please indicate relationship _____

Notice of Privacy Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU OR YOUR CHILD MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

TOTH SPEECH SERVICES', LLC LEGAL DUTY

Toth Speech Services, LLC 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

Toth Speech Services, LLC uses your personal health information primarily for treatment, conducting internal administrative activities and evaluating the quality of care that we provide. For example, we may use your personal health information to contact you to provide appointment reminders, or for information about treatment alternatives or other health related benefits that could be of interest to you.

Toth Speech Services, LLC may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, or for research studies and for emergencies. We also provide information when required by law.
In any other situation Toth Speech Services' LLC policy is to obtain 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 that time.

Toth Speech Services, LLC may change its policy at any time. When changes occur, a Notice of Information Practices will be provided to you. You may also request an updated copy of our Notice of Information Practices at any time.

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PATIENT'S INDIVIDUAL RIGHTS

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 an emergency circumstance. Toth Speech Services, LLC will consider all such requests on a case-by-case basis but is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Toth Speech Services, LLC 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, you may send a written complaint to the US Department of Health and Human Services.

YOU MAY KEEP THIS NOTICE FOR YOUR RECORDS

PATIENT'S NAME: _____

DATE OF BIRTH: ___/___ /_____

Medical Practice Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of the Notice of Privacy Practices. This Notice of Privacy Practices describes the types, uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Toth Speech Services' health care operations. This Notice of Privacy Practices also describes my rights and duties with respect to my protected health information.

Toth Speech Services, LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

Patient Signature:_____ DATE: ___/___/_____

Print Name: _____

If other than patient, please indicate relationship _____

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Designated Individuals Form

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, the treatment of my family member, or of the hereby stated legally represented for payment or administrative operations or as it relates to evaluation and treatment. I understand that I have the right to know at all times what information is shared. I understand that the identity of the designated parties must be verified before the release of any information. I know that I have the right to revoke this authorization at any time in writing.

CLIENT'S NAME: _____

DATE OF BIRTH: ____/____/_____

Authorized Designees: Toth Speech Services, LLC (and treating therapists of Toth Speech Services, LLC)

****Referring Physician is Mandatory:**

PHYSICIAN NAME: _____

Address to where information should be sent:

_____

CITY, STATE, ZIP _____

PHONE # _____

Type of information released: _____

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On the following lines, please write in name of school, teacher, and other treating physicians or therapists if applicable.

NAME: _____

Relationship to patient: _____

Address to where information should be sent:

_____

CITY, STATE, ZIP _____

PHONE # _____

Type of information released: _____

NAME: _____

Relationship to patient: _____

Address to where information should be sent:

_____

CITY, STATE, ZIP _____

PHONE # _____

Type of information released: _____

Signature: _____ DATE: ____/____/_____

Print Name: _____

Relationship to patient: _____

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SCHEDULING POLICY

The therapists at Toth Speech Services, LLC are here for you and want to help you in the most effective and efficient ways possible. We take great pride in providing natural environment therapy services and kindly ask that you consider our travel time when we are coming to your home, school or like environments to provide our professional services. Therefore, it is your responsibility to be on time for your scheduled appointment. Since many of our therapists are on the road all day throughout the SE FL area, we often cannot account for traffic issues or therapy appointments that may run over before your scheduled session. As a result, our therapists try their best to be on time. It is similar to when you go to see your physician and often have to wait in the waiting room until your doctor is ready to see you. Please be advised that should you decide to leave the appointment location due to your therapist's late arrival; you will be charged for the session. In these situations, we will do our best to text or call you to advise you of the backup. However, we still plan for our client's session and travel to you as if the session took place. Thus, we need to compensate our therapists. We appreciate your understanding in this sensitive matter. We look forward to working with you and are glad you are here.

Regards,
Maria E. Toth, MS, CCC-SLP

Patient Name (print) _____
Patient Signature (or parent) _____
If patient is unable to sign, please indicate your relationship to patient:
_____

Date of Signature: ___/___/_____

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Media Release Form

I, _____am the parent/guardian of _____ (referred to as "my child"), and participate in therapy services with Toth Speech Services, LLC.

I hereby consent to the taking of photographs and videos of him/her on behalf of Toth Speech Services, LLC. I also grant the right to edit, use and reuse said products for non-profit, non-commercial purposes, including in print, online, social media and all other forms of media. This includes sharing with parents to document child's progress. I give this authorization without expectation of compensation.

This consent will remain in effect until I revoke it in writing.

CHILD'S NAME: _____

PARENT/GUARDIAN SIGNATURE: _____

PRINT NAME: _____

RELATIONSHIP TO CHILD: _____

DATE: ___/___ /_____

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Credit Card Payment Authorization Form

ALL Toth Speech Services, LLC clients are required to keep a credit or debit card on file for payment services as a backup payment method should your account go into outstanding balance status. Our system enables us to maintain your information securely and only accessed under the terms you specify below. Form completion allows Toth Speech Services, LLC permission to automatically charge your credit card each session for the amount due for services to be rendered, should credit or debit card be your chosen method of payment. If the credit card info we have on file changes, you must notify us ASAP.

*Any account that defaults due to an expired/invalid card will be charged a late fee of $25 every 5 days until the account is updated.

For HSA card users, please authorize charges ahead of time with your HSA company, as TSS will not be held responsible for denied charges once completed. If you have any questions about a charge, please notify us within 15 days. After that time, all charges will be assumed to be correct. We will maintain clear record of all payments and charges. However, in the rare case that an overpayment occurs, your account will be credited on the upcoming invoice or if the balance is zero and you have taken a break from therapy a reimbursement can be applied to the card. A receipt will be sent to you from Intuit (our credit card processing company). Scheduled sessions resulting in a "no show" or cancelled less than 48 hours before the session will be charged at a rate of $85.00 or one session for clients who purchase a package of services. One cancellation (excluding "no shows") within a 24-hour period due to emergency or illness will be allowed at no charge once every 3 months. Phone calls with our therapists are complementary up to 10 minutes in length and after 10 minutes billed at $5.00/minute. Therefore, it is recommended that lengthy conversations take place during session time only or that a follow up session be scheduled. One year after initial evaluation, a mandatory re-evaluation will be scheduled for $225.00 for all clients. Sometimes, insurance companies require these re-evaluations to be completed every six (6) months. In that case, the cost will be $175.00.

*A 3.5% service fee will be charged to each transaction.

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I HAVE READ AND UNDERSTAND THE CREDIT CARD ON FILE AGREEMENT AND AUTHORIZE TOTH SPEECH SERVICES, LLC TO CHARGE MY CREDIT CARD AS STATED ABOVE.

CLIENT'S NAME: _____
DATE OF BIRTH: ____/____/_____
EMAIL: _____

CARD TYPE:

☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS ☐ DISCOVER
☐ OTHER: _____

Cardholder's Name: _____
Card Number: _____
CVC Number: _____ (3 or 4 digits on the back)
Expiration Date: ____/____

BILLING ADDRESS (where you receive statements):
_____
_____
_____

Cardholder's Phone: _____

CARDHOLDER'S SIGNATURE

X_____ DATE: ____/____/_____

Print Name: _____