ADULT INFORMATION PACKET
DIAGNOSTIC EVALUATION

Cover letter
Driving Directions to CSHC

*If you intend to seek insurance reimbursement…..**
*Patient Intake & Insurance Information**
*Case History Form**
*Medication Record**

MEDICARE PATIENTS
*Medicare regulations governing outpatient rehabilitation services**
*Determining if Medicare is the primary payor**

Return these forms to CSHC before scheduling a diagnostic appointment

To whom it may concern:

Your physician has referred you to Columbus Speech & Hearing Center for a speech/ language/ swallowing or occupational therapy evaluation.

In order to proceed with scheduling an appointment, please complete the enclosed documents and return them to us as soon as possible. When we receive the completed documents, we will contact you to schedule the evaluation appointment.

Please tell us the best way to contact you (check all that apply):

- Phone – give us the number to call _____
- Text – give us the number to text _____
- EMAIL – give us your email address _____

Please tell us when it is best to contact you _____

If you have questions about scheduling, contact Miranda Hardy at 706-324-6112, ext. 204. Feel free to leave her a voice message if she is not available.

Please note that once your evaluation appointment is scheduled this time is dedicated to you. If you need to cancel or change the appointment, please contact us 48 hours prior to the appointment to avoid a $50.00 rescheduling fee.

We look forward to seeing you soon.

Columbus Speech & Hearing Center

Enclosed forms for your general information:

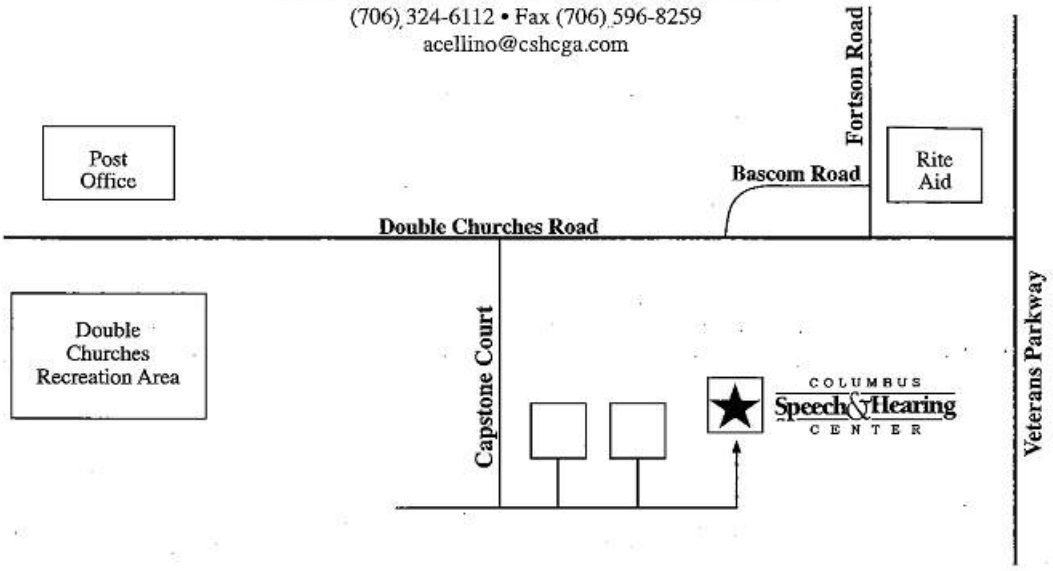
1. *Driving directions to Columbus Speech & Hearing Center*
2. *If You Intend to Seek Insurance Reimbursement*

Materials to return to Columbus Speech & Hearing Center before an initial visit is scheduled:

1. *Case History Form*
2. *Patient Insurance Information*
3. *Adult patient intake and insurance information form*
4. *Brief adult case history form*
5. *Medication record*
6. *Medicare only: Medicare regulations governing outpatient rehabilitation services*
7. *Medicare only: Determining if Medicare is the primary payor*

Directions to Columbus Speech & Hearing Center

COLUMBUS
Speech & Hearing
CENTER
2424 Double Churches Road • Columbus, GA 31909
(706) 324-6112 • Fax (706) 596-8259
acellino@cshcga.com



Coming from LaGrange/Atlanta (I-185 South)

- Take Williams Road, Exit 12
- Turn Left onto Williams Road
- Continue on Williams Rd for almost a mile
- Turn Right onto Fortson Road
- Stay on Fortson until you come to traffic light
- Turn Right onto Double Churches Rd
- Pass Palms Apts on Left; CSHC is next entrance on Left

Coming from Ft Benning (I-185 North)

- Take Exit 10 towards US-27/US-80/GA22/Macon/Phenix City, Al
- Keep Right to GA-22 East/US-80E ramp towards US-27 Macon
- Keep Right to take Veterans Pkwy ramp
- Turn Right on Veterans Parkway
- Cross over I-185; Turn Left onto Double Churches Road
- Pass North Lake Center and Palms Apts; take next entrance to Left to CSHC

Coming from East/Midland (JR Allen/US-80)

- Take Exit 4 towards I-185/Atlanta/Ft Benning
- Keep Right to US-27/GA-1/Veterans Pkwy ramp
- Go through traffic light onto Double Churches Road
- Pass North Lake Center and Palms Apts; take next entrance on Left

Coming from Phenix City (US 80 East)

- Take Exit 4 towards US-27/GA-1/Veterans Pkwy/Moon Road/I-185/Ft Benning/Atlanta
- Stay in Right lane and merge onto Veterans Pkwy/US-27 N/GA-1 toward Hamilton
- Turn Right onto Veterans Parkway
- Turn Left onto Double Churches Road
- Pass North Lake Center and the Palms Apts; take next entrance on the Left

IF YOU INTEND TO SEEK INSURANCE REIMBURSEMENT

Columbus Speech & Hearing Center is an approved provider for multiple insurance companies. You should know that insurance companies frequently list speech therapy, audiology, and occupational therapy as reimbursable services, but that is not a guarantee of payment, particularly if the disorder is not due to a "medical" condition. Before your first visit, our staff will contact your insurance company and determine if the diagnostic evaluation is covered, if you have related deductible or co-pay. We will share that information with you before your visit here.

Before your first visit, we need:

1. Your physician to send us a prescription for a speech, language, occupation, balance and/or hearing evaluation. These scripts are faxed to our office (Fax: 706-596-8259)
2. A copy of your insurance card, front and back. You may provide that at your appointment here.
3. A completed *Patient Intake and Insurance Information* form, which is enclosed

If therapy is needed and you intend to seek insurance reimbursement:

1. Insurance companies typically require a written Diagnostic Evaluation, which we provide with a request for prior authorization of therapy. We notify you of their response before therapy starts.
2. Insurance companies may require periodic (usually on 6 month intervals) re-evaluations with progress reports. These entail additional reports, updated treatment plans, and staff time. Applicable fees are charged to the patient as "Additional services".
3. In general, we cannot negotiate with your insurance company on your behalf. In case of denials, we will provide any information they request, such as diagnostic reports or daily treatment notes. Will share all knowledge we have of what triggered the denial. If it is due to clerical error on our part, we will correct those errors and resubmit the claim. If it is due to the insurance company's coverage restrictions, we cannot negotiate with them on your behalf.
4. You are ultimately responsible for payment in full for any professional services rendered, regardless of your insurance status. Understand that prior authorization for a procedure is not always a guarantee of payment by the insurance company.

_____

Patient/Guardian signature indicating receipt and understanding of information above Date

_____

ADULT PATIENT INTAKE AND INSURANCE INFORMATION

	LAST NAME	*FIRST NAME*	*MI*	*BIRTHDATE*

PRIMARY CARE PHYSICIAN	*SOCIAL SECURITY NUBER*	*SEX*

ADDRESS:

OCCUPATION:

EMPLOYER:

HOME PHONE:

CELL PHONE:

WORK PHONE:

EMAIL:

INSURANCE IDENTIFYING INFORMATION

	PRIMARY INSURANCE	*SECONDARY INSURANCE*
NAME OF INSURANCE		
NAME OF POLICY HOLDER		
RELATIONSHIP TO PATIENT		
POLICY NUMBER		
GROUP NUMBER		
PROVIDER CUSTOMER SERVICE NUMBER		
PLAN TYPE: HMO, POS, PPO		

PATIENT VERIFICATION OF ACCURATE INSURANCE INFORMATION AND RESPONSIBILITY FOR PAYMENT

I understand and agree that I am ultimately responsible for payment in full for any professional services rendered, regardless of my insurance status. The information listed above is true and accurate to the best of my knowledge. I understand that all claims are subject to individual contract policy and to medical necessity review. Prior authorization for a procedure is not a guarantee of payment. I will promptly notify you of any changes in my health care coverage or the above information.

_____ _____

Patient signature *Date*

_____

Given to Patient on Date: *Received from Patient on Date:*

BRIEF ADULT CASE HISTORY FORM

PATIENT: _____ DATE_____

SPEECH-LANGUAGE HISTORY

What is the reason for today's visit? What are your concerns?
What was your level of function before the current problem began? How has your speech/language changed?
Have you had prior treatment for this problem? Where? When? What were the results?
How is the speech/language problem affecting your work? Your social interactions?
What are your main goals of therapy?

MEDICAL HISTORY

Your Primary Care Physician:	Referring physician:
Describe history of current condition for which treatment is sought. When did it begin? Have the symptoms changed? Gotten better or worse?	
Related health conditions: Any history of: 0Previous stroke? 0 Neck surgery? 0 TBI 0 Dementia? 0 Acid reflux? 0 Neurological Disorder? 0 Thyroid problem?	

WORK HISTORY

Describe your current job responsibilities:
What are your usual weekly talking needs? How much to individuals' vs groups? Your routine job requirements?

EDUCATIONAL HISTORY

How many years of schooling?	Where/when?
Special training?	

OTHER

Living arrangements: 0 Alone 0 Assisted 0 Lives with:

REPORTS TO:

MEDICATION RECORD

PATIENT: _____ DATE_____

If you are currently taking any medications, please list them below. Use the back of this page if necessary.

G8427	*CURRENT MEDICATIONS*				
	Name of Medicine	Dosage	Frequency	Route (oral or injection)	Comment

G8427	*OVER THE COUNTER DRUGS*				
	Name of Medicine	Dosage	Frequency	Route (oral or injection)	Comment

G8427	*HERBALS*				
	Name of Medicine	Dosage	Frequency	Route (oral or injection)	Comment

G8427	*VITAMINS/MINERAL/DIETARY/NUTRITIONAL SUPPLEMENTS*				
	Name of Medicine	Dosage	Frequency	Route (oral or injection)	Comment

/__/ I am NOT currently taking any medications (prescription, over the counter, herbal or vitamin)

_____ _____

PATIENT SIGNATURE DATE

MEDICARE REGULATIONS GOVERNING OUTPATIENT REHABILITATION SERVICES

To insure maximum coverage for your speech and hearing rehabilitation and avoid any misunderstandings, there are several ***Medicare Regulations*** of which you should be aware.

- Medicare has an annual cash deductible of $183.00 which must be met before your coverage is effective. If this amount is paid during the last three months of the year, the amount paid during that period will be carried forward and applied to the up-coming year's deductible amount.
- Medicare outpatient coverage is 80% of reasonable charges. You are responsible for paying the other 20%. For children under 21 years of age who qualify for Medicaid, the 20% co-insurance portion is paid by Medicaid. Secondary insurance policies may pay the 20% co-pay. This should be confirmed in advance with our billing department.
- You (Medicare patient) can be accepted for outpatient speech pathology therapy, or audiological testing, or occupational therapy only on the written referral of your physician.
- Your attending physician will receive a copy of your initial evaluation report and Plan of Care within 10 days of your initial visit here.
- Subsequent Updated Plans of Care are forwarded to your attending physician every 30 days.
- Re-certification of continued need by the attending physician and therapist must be documented every 90 days.
- You must be under the care of your attending physician with his/her reports of his/her findings incorporated into your clinic file (speech, hearing, occupational therapy)
- Forms to be completed by your attending physician will be mailed to your doctor or given to you at the appropriate time.

To insure continued re-certification, your responsibilities are to:

1. Inform your physician of your desire to receive speech-language, audiology, or audiology services, thereby insuring his/her support.
2. Arrange for a regular check-up with your physician, hand carry your re-certification form to your physician. This will allow him/her to review your progress and re-certify your continued need for treatment. Return the above signed re-certification to your clinician at your next therapy visit.

I have read, understand, and agree to abide by the above regulations.

_____

SIGNATURE DATE WITNESS DATE

DETERMINING IF MEDICARE IS THE PRIMARY PAYOR

QUESTION	NO	YES	
1. Is the patient 65 or older? 2. Is the patient employed? 3. Is the patient covered by an Employer's Group Health plan?	_____ _____ _____ _____	_____ _____ _____ _____	If Yes to # 3, list the name, address and ID # on the card
1. Is the patient's spouse employed? 2. If YES, does the spouse have dependent coverage on his/her Group Health Insurance?	_____ _____	_____ _____	If Yes to # 2, list the name, address and ID # on the card
1. Is the patient a disabled Medicare beneficiary? 2. Is injury/illness due to a work related accident? 3. Is injury/illness due to an automobile or liability accident?	_____ _____ _____	_____ _____ _____	If Yes to # 3, explain
1. Does the patient suffer from kidney failure? 2. Does patient have Veterans' Administration benefit coverage? 3. Does patient have any other insurance coverage that will pay for therapy before Medicare?	_____ _____ _____	_____ _____ _____	If Yes to # 3, list the name, address and ID # on the card

By answering the preceding questions, I have established Medicare as the primary/secondary payor (circle one). If Medicare is primary, I understand that I am responsible for any deductibles and coinsurance. If Medicare is secondary, I understand that Columbus Speech & Hearing Center will file my primary insurance before filing Medicare.

_____ _____

PATIENT SIGNATURE DATE

SIGNATURE PAGE

Instructions: Please **initial** beside each of the following items, indicating your authorization or agreement.

Date	Yes, I agree	No, I do not agree	
			CONSENT FOR TREATMENT I hereby consent to such diagnostic procedures, and medical treatment, which in the judgment of my Physicians may be considered necessary or advisable while a patient at Columbus Speech and Hearing Center
			ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Columbus Speech & Hearing Center of the Medical Benefits, otherwise payable to me for services described above, but not to exceed reasonable and customary charges for those services. I understand and acknowledge that this assignment does not relieve me of my financial responsibility. If payment has not been received from the insurance carrier, *I accept personal liability for the charges not reimbursed by Insurance within 45 days.*
			AUTHORIZATION TO RELEASE INFORMATION: I consent to the release of relevant diagnostic, therapy , or other related materials to qualified professional personnel in furtherance of clinical services on behalf of me or my minor being seen; or for whom I am legally responsible, as deemed medically necessary by the attending Speech-Language Pathologist and/or Audiologist at Columbus Speech and Hearing Center.
			ACKNOWLEDGEMENT OF RECEIPT OF *NOTICE OF PRIVACY PRACTICES* **(**you may refuse to sign this acknowledgement) I have received a copy of this office's *Notice of Privacy Practices.*

_____ _____

Signature Date Witness

MEDICARE OR MEDICAID AS SECONDARY INSURANCE

I am aware that I am personally responsible for any and all Medicare co-pays, co-insurance, and deductibles for Speech and/or Hearing evaluations or therapy. I am aware that Columbus Speech and Hearing Center cann not bill Medicaid for services rendered on patients over 21 years of age. I agree to pay all monies due to Columbus Speech and Hearing Center at the time services are rendered or upon receipt of an invoice for services rendered by Columbus Speech and Hearing Center.

_____ _____ _____

Patient Name Date Parent/Guardian Signature/Date Witness