330 S Madison Ave Suite 106

Bainbridge Island WA 98110

(206) 451-4308

Adult Intake Form

Date : ___________________________

Patient Information

Patient Name (first, middle, last): ____

Nickname: __________________ **Birthdate:** ___________ **Gender:** ____________

Pronouns: __________________

Referral

Referring Physician : ____

Physician Phone: _________________________ **Fax:** ________________________

Primary Care Physician : ____

Physician Phone: _________________________ **Fax:** ________________________

Were you referred to our office? By Whom? __________________________________

Doctor Friend Insurance School Therapist Website Other

Insurance Information

Please provide a copy of both sides of your insurance card. If you have more than one form of insurance, please provide us with a copy of the front and back of all your cards.

Please also provide a copy or the picture identification of the primary insurance holder.

Cash Pay Information

You/your family has the right to be provided with a good-faith estimate of the costs of services. AASLC will provide that good-faith estimate either at the time the service is scheduled or upon your request. We will need to complete a formal Evaulation to determine the approximate duration of your plan of care.

Describe the primary reason you are seeking speech and language therapy.

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Pertinent Medical History:

Reflux/GERD/LPRD Current reflux medication and dosage/frequency:

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Swallowing or Esophageal disorders: Explain:

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History of aspiration Pneumonia:

Date:______________________

Neurological deficits: Explain:

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Cardiac problems/disorders: Explain:

Pulmonary/Respiratory disorders: Explain:

History of Voice Problems: Explain:

Do you have allergies?: Yes No If so, please specify:

Give name of eye doctor and date of last evaluation:

Does this patient have a hearing loss? Yes ☐ No ☐

Wear a hearing aid (R or L ear)? Yes ☐ No ☐

When and where was this patient's hearing last evaluated?

Other Medical History:

Other including any surgeries or hospitalizations:

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Current Medications including over-the-counter:

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If the patient was previously enrolled in speech-language therapy, indicate where and the clinician's name(s) (if you recall them):

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"I understand that it is my responsibility to inform AASLC of any changes to my health, such as a new diagnosis, medical procedure or hospitalization. I will inform AASLC if another provider has been added to my care team so that my care is coordinated appropriately. I will also inform AASLC if there are any changes to my insurance coverage."

____

Signature of authorized representative NAME Date

CONSENT TO USE PHOTOGRAPHS
IN PUBLICITY OR ADVERTISING

The purpose of this form is to provide my consent for The Aubin Aphasia Speech and Language Center (AASLC) to use photographs of me for publicity or advertising purposes.

I agree to hold AASLC harmless for any liability associated with this use of my photographs. I understand that I will receive no compensation or royalties, nor any revenue that might result from these publicity or marketing efforts. I waive my right to inspect the final publicity or advertising materials. I acknowledge that, while I may withdraw my consent at any time, such withdrawal will not apply to publicity or advertising material that has already been published in accordance with this consent. Although AASLC will not publish my name or contact information, I understand that I am personally identifiable by these clinical photographs and hereby agree to this loss of privacy.

I understand that I am under no obligation to provide this consent.

By my signature below, I certify that I am at least 18 years of age and competent to consent to AASLC's use of photographs of me for publicity or advertising purposes.

__________________________________ (signature)

By: ______________________________ (printed name)

________________________ (date)