Updated 2/7/18

Carter Swallowing Center

CONSENT FOR TREATMENT AGREEMENT

Patient Information

Name: _____Date of Birth: _____ Age: _____

Name you prefer to be called: _____

Address: Street_____

City _____ State: _____ Zip code: _____

Preferred contact phone number: _____

May we leave a voice mail at that number? YES NO

Preference for appointment reminders: (circle choice) Text Email

Cell phone provider (for texts) OR email address: _____

Person to contact in case of emergency: _____

Relation to patient: _____ Phone number: _____

Are you currently receiving medical care in your home (home health nursing, PT, speech therapy)? YES NO

If YES, please contact us before your appointment as your insurance may not cover services at our clinic.

If you were not referred to our center by your physician, how did you hear about the Carter Swallowing Center? _____

We will send a copy of your swallowing evaluation to your referring physician. Let us know if there are other medical professionals that you want to receive a copy. (name/phone #)

_____

_____

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Medical History

Other physicians you have consulted regarding your current condition: _____

_____

Major illnesses, diseases or injuries_____

_____

_____

List the prescription medications you take (indicate the condition for which you take each medication?

_____

_____

Do you take the following: ☐ muscle relaxers ☐ prescription pain medication

Do you have a history of any of the following?

☐Allergies ☐Pneumonia ☐Cancer (type) _____

☐Acid reflux ☐Heart disease ☐Neurological condition (stroke, neuropathy, etc.) _____

Do you have any of the following?

☐Pacemaker ☐Deep brain stimulator ☐History of seizures

☐Other implanted electronic devices ☐Other implanted metal ☐ Carotid artery blockage/stent

Do you have any surgeries scheduled in the next 6 weeks? If so, please list:

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Swallowing History:

Briefly describe your swallowing difficulty or concerns: _____

_____

Have you had speech or swallowing therapy before? If so, where and when? _____

_____

To what extent are the following scenarios problematic?	**0= No problem**				**4= Severe problem**
My swallowing problem has caused me to lose weight	**0**	**1**	**2**	**3**	**4**
My swallowing problem interferes with my ability to go out for meals	**0**	**1**	**2**	**3**	**4**
Swallowing liquids takes extra effort	**0**	**1**	**2**	**3**	**4**
Swallowing solids takes extra effort	**0**	**1**	**2**	**3**	**4**
Swallowing pills take extra effort	**0**	**1**	**2**	**3**	**4**
Swallowing is painful	**0**	**1**	**2**	**3**	**4**
The pleasure of eating is affected by my swallowing	**0**	**1**	**2**	**3**	**4**
When I swallow food sticks in my throat	**0**	**1**	**2**	**3**	**4**
I cough when I eat	**0**	**1**	**2**	**3**	**4**
Swallowing is stressful	**0**	**1**	**2**	**3**	**4**

Do you avoid certain foods or liquids because they are difficult to swallow? ❑ Yes ❑ No

If so, please list examples: _____

_____

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Do liquids ever come back through your nose when you swallow them? ❑ Yes ❑ No

Is your swallowing problem intermittent / constant? (Circle one)

Has your swallowing problem changed over time? ❑ Yes ❑ No

If so, please describe:_____

Are there any factors that make your swallowing problem worse? ❑ Yes ❑ No

If so, please describe:_____

Are there any factors that make your swallowing problem better? ❑ Yes ❑ No

If so, please describe:_____

Within the past month, how severe were the following symptoms?
0= No problem
5= Severe problem

	0	1	2	3	4	5
Hoarseness or a problem with your voice?						
Clearing your throat?						
Excess throat mucus or postnasal drip?						
Coughing after you ate or lie down?						
Breathing difficulty or choking episodes?						
Troublesome or annoying cough?						
Sensation of something sticking in your throat or a lump in your throat?						
Heartburn, chest pain, indigestion, or stomach acid coming up?						

Please indicate the symptoms you have:

☐hoarseness ☐pain in throat while speaking

☐breathy voice ☐"strained" or "tight" voice

☐vocal fatigue ☐bitter taste in the morning

Cancellation and No Show Policy

I understand that I must give at least **24-hour notice** of the cancellation of a therapy session which can be made by contacting the Carter Swallowing Center.

I also understand that if at any time I "no-show" for a scheduled appointment without calling, I may be charged a **$50 fee for each missed appointment.** Participant may be subject to discharge from the clinician's caseload due to no-shows or cancelations at the clinician's discretion.

I acknowledge by my signature that I have read the above and agree to the stated terms.

Responsible party: _____Date:_____

Billing Information:

Person responsible for payment: ☐Self ☐Other

Please complete below *if a person other than the patient is responsible for payment*.

Name: _____ Relationship to Patient: _____

Address: _____

Home phone: _____ Work phone: _____

Insurance Information

☐I choose to self-pay. Accepting the self-payment rate waives my ability to submit claims to insurance.

☐Please submit my bill to my medical insurance. (We will need a copy of your insurance card/cards)

It is your responsibility to notify the Carter Swallowing Center if you change insurance policies.

I declare that I have provided all the medical/health insurance plans from which I may receive benefits.

Signature of patient_____ Date_____

Pre-authorization for Treatment

We will verify your benefits using the information you provide about your insurance company before your first appointment. We cannot guarantee the accuracy of the information the insurance company provides us, and *we encourage you to check your benefit for speech or swallowing therapy directly with your insurance company as well*.

Insurance and Billing

The financial obligation for this account is yours. We will take all reasonable steps to bill your insurance company as a courtesy to you and will do all that we can to collect on legitimate claims. However, in the event your insurance company denies the claim for any reason, you will be responsible for payment of this account.

All balances, after insurance payment has been received, are due and payable upon receipt of last insurance monies received. In addition, I agree that in the event that I do not make a payment and Carter Swallowing Center, LLC proceeds with collection actions on the balance due, then I will be responsible for all costs of collection, including court costs and attorney's fees.

I acknowledge by my signature that I have read the above and agree to the stated terms.

Responsible party: _____Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Carter Swallowing Center's privacy practices are available on request.
Would you like a written copy of the HIPAA policy? YES NO

I, _____, have been given the opportunity to view this office's Notice of Privacy Practices (HIPAA).

_____
Please Print Name

_____
Signature Date