Annual Client Update Form

Client Name: _____ Date of Birth:_____
Social Security # (required): _____

Has your home address changed in the past 12 months? ☐ **Yes** ☐ **No**
If yes, please update the address below:

Address: _____ Work Phone:_____
_____ Cell Phone: _____
Preferred method of communication: Email: _____
☐ **E-mail** ☐ **Text** ☐ **Phone call**

Has there been a change in insurance coverage or additional plans over the past 12 months? ☐ **Yes** ☐ **No**
If yes, please update the new insurance plan(s) below:

Current Insurance Company:_____ **Medicaid:** ☐ **Yes** ☐ **No**
Current Insurance #: _____

Secondary Insurance Company:_____ **Medicaid:** ☐ **Yes** ☐ **No**
Secondary Insurance #: _____

Has your child's Primary Care Physician Changed in the past 12 months? ☐ **Yes** ☐ **No**
If yes, please update your child's new provider below:

Primary Care Physician Name:_____ Physicians Phone:_____
Physicians Address: _____

Consent to Treat Statement: The above individual, consents to be evaluated and/ or treated by SpeakEasy Therapy Factory to determine necessity for, and frequency/duration of ST, PT or OT services. If you agree to this evaluation, a licensed, certified Speech- Language Pathologist, Physical or Occupational Therapist will perform a diagnostic evaluation (including standardized and non- standardized testing, swallow exam, and/ or clinical observations) and provide subsequent treatment, if needed. Therapy goals will be determined based upon the results of the evaluation, the recommendations of the evaluating therapist, and caregiver input. *Completion of this form will allow us to verify your benefits, so we can discuss insurance payment and any fees/ co- pay charges after insurance coverage is applied. SpeakEasy Therapy Factory **CANNOT** provide services without verification of insurance and/ or an agreement on a payment plan if necessary.

I hereby give consent to be evaluated and/ or treated by SpeakEasy Therapy Factory

_____
Clients Name (Printed)

_____
Caregiver/Parent/Guardian Name (Printed)

_____ _____
Client/Caregiver/Parent or Guardian Signature **Date**

Please return this competed form to SpeakEasy Therapy Factory prior to initial visit via fax or email.
Email: info@speakeasytherapyfactory.com Fax: 803-470-4709 Phone/Text: 803-400-6334

Scheduling, Cancellation & Attendance Policy

Scheduling:

Your assigned therapist will reach out to schedule a day and time of the week which works for you both. Please respond to calls, emails and or text messages to schedule and to confirm therapy sessions as soon as possible. It is highly recommended that the child's parent(s) or caregiver(s) remain for the duration of the session. It is critical to the success of the child's progress, for caregivers to exhibit knowledge and understanding of therapy techniques to carryover with the child between sessions. The more a child practices what they learn in therapy with family, peers, and caregivers, the faster they will improve.

No Call- No Show's: *(3 NCNS's within a 2- month period will result in an automatic discharge)*

- Failure to respond to calls, or texts to schedule/ confirm appointments
- Not informing therapist of a change to appointment at least 2 hours prior to the start of a scheduled session
- Client is not home or is unavailable for scheduled visit when therapist arrives

Canceled Sessions: *(Please Initial each)*

_____ Please call, text, or email as soon as possible, but at minimum of 2 hours prior to an appointment if you need to cancel or reschedule. *(It will otherwise be considered a NCNS)*

_____Appointments may be canceled or rescheduled if the child is ill, or if a family emergency arises. **Please inform your therapist ASAP and adhere to the 2-hour minimum time window.** The therapist and parent will then agree on a time and date to reschedule the missed session(s).

_____**If you cancel your session using the" text message confirmation" feature, please ALSO contact your therapist via phone, text or email to discuss the cancellation, and to schedule a make- up visit.**

_____**All insurance companies and BabyNet are informed of missed visits as a result of No Call- No Show's.** It is required for SpeakEasy Therapy Factory to report this information to them. Missed visits are taken into consideration by the insurance companies and can negatively impact their decision to grant additional therapy visits, which need to be renewed every few months.

Photography Release: *(Initial ONE response "Yes" or "No")*

_____ **Yes**, I consent for photographs and/or video images to be taken of me by SpeakEasy Therapy Factory, LLC. or a representative. I understand the images will be a part of my medical record and may be used for purposes of medical teaching or training or for marketing purposes (website, print, digital or social media). By consenting to photographs and/or video images I understand I will not be compensated from any party. Although photographs and/or video images will be used without identifying information such as name, I understand it is possible someone may recognize me. I further acknowledge that my participation is voluntary and agree that use of any photographs and/or video images confers no rights of ownership or royalties whatsoever.

_____ **No**, I decline to give consent for use of photo(s) and video(s) of my child during therapy. I understand that declining will not impact the quality of therapy services that my child receives.

By signing this form, you are confirming that you have been given a copy, and that you understand and agree to the scheduling, photo release, and cancellation & attendance policy.

Clients Name (Printed)	**Parent-Guardian/ Caregivers' Signature**	**Date**