ARRIVE 10 Minutes EARLY for this Evaluation !!!
BRING this PAPERWORK back COMPLETED
along with your ID, INS CARDS, & List of MEDS

1317 Ebenezer Rd Rock Hill, SC 29732 803-207-8177

Name: ________________________ Date of Birth: _______________

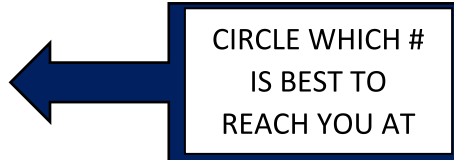
Address: ____

Phone Numbers:

Home __________________________

Mobile __________________________

Email: ____________________________________



CIRCLE WHICH # IS BEST TO REACH YOU AT

Pick ONE way to be reminded of appointments on the number you circled above ?

Call / Text / Email

PRIMARY Insurance :______________________________ Member Number: ___________________

Responsible Party: Self _____ Spouse _____Child _____

Responsible Party's Name : ______________________ & Date of Birth : _____/_____/________

SECONDARY Insurance : (if applicable):__________________ Member Number: __________________

Responsible Party: Self _____ Spouse _____Child _____

Responsible Party's Name : ______________________ & Date of Birth : _____/_____/________

Emergency Contact:

Name : _____________________________________ Number : _____________________________

Consent to Therapy Treatment

I hereby consent to the treatment of my condition by a licensed therapist. I understand that I will receive an initial evaluation which will now be followed by one or several treatment sessions. These sessions may include one or more of the following: physical therapy, Joint mobilization, manipulation, soft tissue work, manual therapy, electrical stimulation, ultrasound, heat / ice, mechanical / manual traction, passive / active range of motion, strengthening, stretching, exercise, activities of daily living modification, and/or speech therapy.

Release of Information

I hereby authorize release of information necessary to file claims with my insurance company and information to my physician/s. I permit a copy of this authorization to be used in place of the original.

Receipt of Privacy Practice

I have received a copy of The Notice of Privacy Practices and have had an opportunity to ask questions.

Patient Signature: __________________________________ **Date:** ___________

Cancellation/Attendance/Late Policy

We take pride in providing quality rehabilitation service to our patients. In order to receive maximum benefit from your therapy treatments, we ask a few things of our patients:

● We ask that you arrive on time for your therapy appointments. If you arrive 15 minutes late, we reserve the right to reschedule your appointment.

● If you are unable to keep your appointment, we ask that you notify us by 10:00 am the day prior to your appointment at 803-207-8177

● If we do not receive at least 24hr advance notice from you, you will be charged a $25.00 cancellation fee prior to receiving your next scheduled treatment.

● In the event of three (3) appointments that have been missed with or without notification, we reserve the right to discharge you from your rehabilitation services.

● We ask that you perform your HEP (Home Exercise Program) as prescribed.

Insurance Verification

We will gladly file your insurance claim for you; however, Revo Rehab, INC does not guarantee payment by the insurance company for services rendered. In the case that your claim or a portion there of is denied, you will be responsible for payment of the remaining balance.

Medicare Beneficiaries:

We are required, by law to inform you that Medicare Part B will cover 80% of the cost of therapy. The remaining balance may be covered by supplemental insurance coverage or may be paid out-of-pocket. After the claim is initially filed, you will receive a letter of denial from Medicare. We will receive the same letter of denial, and at that time Revo Rehab, INC will bill the remaining claim with the supplemental insurance, if applicable.

Please Direct Any Therapy Concerns to Dr. Ashley Fann &

Any Billing Concerns to Kim Huddleston

at 803.207.8177 or revorehab2018@gmail.com

I give permission for rehabilitative services to be performed by Revo Rehab, Inc. I will be responsible for payment for services, if the insurance company does not pay.

Assignment of Benefits and Insurance Proceeds

I hereby authorize payment from my insurance company of medical benefits for services provided in Out Patient Therapy by an assignment of benefits. The completion of insurance forms and the assignment of insurance benefits do not relieve the undersigned of the obligation to pay the amount owed for Therapy.

Patient Signature: ________________________________ **Date:** __________

Speech Therapy Case History Form

Name:___________________________________ Date of Birth: _________________________

Referred to this clinic by: ____________________ Primary Care Physician:___________________

Are you: ___single; ___married; ___divorced; ___widowed;___ Spouse/Partner Name : ________________________

Current Occupation: _______________________________ If retired, from what: ________________________

Children (names, gender, ages):____

____

Who lives in your home?

____

Communication History

Describe your current speech, language, cognition (memory, thinking, reasoning), respiratory or swallowing difficulties.

____

____

When was this current problem first noticed? By whom?

____

What do you think may have caused the problem?

____

____

Are there situations where the problem is better/worse?

____

____

Have you seen any other speech-language specialist(s)? Who and when? What were their conclusions or suggestions?

____

____

What have you done to try to improve your communication or current difficulty? What were the results?

____

____

How do you feel your communication problem has affected your social life, career, education, etc.?

____

____

Have you seen any other specialist (physical/occupational therapists, surgeons, physicians, psychologists, neurologists, etc.) concerning your problem? If yes, indicate the type of specialist, when you were seen and the specialist's conclusions or suggestions.

____

____

Are there any speech, language, voice, hearing, or respiratory problems in your family? If yes, please describe.

____

____

What are your goals for coming to the clinic at this time?

____

____

Medical History

Please check the following if they apply:

Hearing Loss _______ Allergies _______ GERD/Reflux _______ Noise Exposure _______

Dizziness _______ LPR _______ Ear Infections _______ Encephalitis _______ Depression _______

Seizures _______ High Fever _______ Head Injury _______ Osteosclerosis _______ Meningitis _______

Stroke _______ Sinusitis _______ Measles/Mumps_______ Concussion _______ Tinnitus _______

Mastoiditis _______ Headaches _______ Pneumonia _______ Chronic Cough _______ Anxiety _______

Asthma _______ Difficulty Breathing ____ Voice Problems _______

Is there a history of: Smoking ______ How much per day? _____________ Drinking ______ How much per day? ______

Describe your present health.

____

Please describe any medical problems you are currently experiencing.

____

____

Do you have any eating or swallowing difficulties? If yes, please describe.

____

____

List all medications and the purpose for each. Please use the back if you need more room.

____

____

Are you having any negative reactions to these medications? If yes, please describe.

____

Describe any accidents, major surgeries, or hospitalizations (including dates).

____

____

In the space below, please provide any additional information that might be helpful in the evaluation or treatment process.

____

____

Person Completing Form: ____

Relationship to Client: ____

Signature: ____Date: ___________