Speech Solutions
Speech Therapy & Orofacial Myology

PATIENT HEALTH HISTORY

Last Name ________________________ First Name _____________________ Today's Date______________

Nickname _________________________ Age _______ DOB _____________ Male ____ Female ____

Address ________________________________ City _____________________ State _____ Zip Code _______

Phone (H) ______________________ (C) _____________________

Email Address ____

School ________________________________ Activities ____

Who referred you to our office? ____

Please give a brief description of the reason for your visit____

____

Responsible Party

Last Name ________________________ First Name _____________________ Home Phone ______________

Address (if different from above) ____

Occupation____________________ Employer ___________________________ Work Phone _____________

____ Single ____ Married ____ Divorced ____ Separated O.k. to contact you at work? Y ____ N ____

Spouse ____ Home Phone______________________

Address (if different from above) ____

Address (if different from above) ____

Occupation____________________ Employer ___________________________ Work Phone _____________

Did the mother have any illnesses or complications during pregnancy and birth? ____ Yes ____ No
If yes, explain:____

____

Did the mother take any prescription or non-prescription drugs (including alcohol) during pregnancy?
____ Yes ____ No If yes, what kind, how often, and how much? _________________________________

____

Was the pregnancy full term? ____ Yes ____ No
If premature, how long was the pregnancy? ____________
How much did the baby weigh at birth? ____________

Did your newborn have any of the following difficulties? ❒ Fever ❒ Allergies ❒ Convulsions
❒ Excessive vomiting ❒ Bleeding ❒ Brain injury ❒ Feeding problems ❒ Breathing problems

Explain any medical difficulties of your newborn ____
____
____

Please give approximate ages at which the following occurred:

Motor Development
Sat alone ________________________ Crawled __________________________
Stood alone ______________________ Walked alone ______________________
Fed self _________________________ Dressed self _______________________
Toilet trained ____________________

Speech/Language Development
Babbled _________________________ Spoke first words ___________________
Put words together ________________

Has the child's development appeared to be normal? ____ Yes ____ No If no, explain___________________
____

III. MEDICAL INFORMATION

Health Care Providers

Dentist:	**Ortho:**
Name:_______________________________	Name:_______________________________
Address: ____________________________	Address: ____________________________
City, State, Zip: _____________________	City, State, Zip: _____________________
Phone : _____________________________	Phone : _____________________________
MD:	**Other:**
Name:_______________________________	Name:_______________________________
Address: ____________________________	Address: ____________________________
City, State, Zip: _____________________	City, State, Zip: _____________________
Phone : _____________________________	Phone : _____________________________

Has the student ever had high fever, serious illnesses, accidents or head injuries? ____ Yes ____ No
If yes, describe and tell at what age it occurred____
____
____

Did the condition described above require treatment in hospital? ____ Yes ____ No
If yes, which hospital and for how long?____
____

Does the student have frequent illnesses or health problems? ____ Yes ____ No
If yes, explain____
____
____

Does the student take a prescription medication? ____ Yes ____ No
If yes, list medication(s), dosage, and purpose____
____

Does the student have vision or hearing problems? ____ Yes ____ No
If yes, explain____

Has the student experienced any events that could affect school performance (death in the family, divorce)?

Does the student have a tendency towards:	**Colds**	**Sore Throats**	**Ear Infections**	**Headaches**

How Often? ____

	Yes	**No**
Have the Tonsils and/or Adenoids been removed? If so, at what age? _____		
Does the client have jaw popping and/or pain?		
Does the client have frequent headaches?		
Has there ever been an injury to the face or mouth?		
As the client ever sucked his/her thumb or fingers? If so, until what age? ________		
Does the client have any speech problems?		
Does the client breathe through his/her mouth while awake?		
Does the client breathe through his/her mouth while asleep?		
Does the client clench or grind his/her teeth at night?		

Please list any drugs or medications currently being taken: ____

Other pertinent Health information? ____

V. EDUCATIONAL BACKGROUND

Has this student been evaluated for special education previously? ______ If so, explain outcome:

Did this student attend kindergarten? _________ Full Day _________ Half Day _______ Didn’t attend

How would you describe the student's ability to learn? ____ Average ____ Above average ____ Below Average

How would you describe the student's effort to learn? ____ Average ____ Great deal of effort ____ Little effort

Has the student ever missed over 10 days of school during the same year? ____ Yes ____ No If yes, explain

Has the student repeated a grade? ____ Yes ____ No If yes, which? _____

READING (decoding)

____ Above average ___ Average ____ Below Average

READING (Comprehension)

____ Above average ___ Average ____ Below Average

WRITTEN LANGUAGE

____ Above average ___ Average ____ Below Average

Describe any concerns the parent has about the student's learning or school performance. ______________

____

____

Strengths/Interests/learning preferences (Please write at least one for each of these areas)

____

____

Motor Skills: Gross Motor (i.e. P.E. skills, running, jumping etc.)

____ Above average ___ Average ____ Below Average

Fine Motor (i.e. writing, cutting, manipulating small objects)

____ Above average ___ Average ____ Below Average

Comments:

____

____

Social/Emotional Development

- ☐ Gets along well with others
- ☐ Adequate social skills
- ☐ Good peer relations
- ☐ Adequate peer relations
- ☐ Social skills need improvement
- ☐ Difficulty maintaining friendships

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DIET JOURNAL

Introduction to 5-7 Day Diet :: It is important to know what foods your child is choosing or not choosing to eat and where they are chewing the food once it is in their mouth. To pinpoint the answers, it is important that you, the food provider, tabulate a 5-7 day diet of what your child is or is not consuming.

1) Please tabulate your child's food choices / preferences: ________________________________
____
____
2) What tastes, textures, temperature and shape do they prefer? __________________________
____
____
3) Is your child biting off food to take in their mouth:
Between front teeth _______
Between middle teeth _______
Between back molars _______
4) Where are they chewing food once it is in their mouth?
Front _______
Middle _______
Back _______
5) Their mouth is opened _______ / closed _______ as they chew.
6) How much jaw movement is accompanying the chewing?
Very little _______
Moderate amount _______
A whole lot _______
7) Is the lower jaw jutting out? Yes _______ No _______
8) Is the lower jaw sliding from side to side? Yes _______ No _______
9) I your child stuffing their mouth regularly? Yes _______ No _______
10) Is your child taking tiny mouse-size bites? Yes _______ No _______
11) Are liquids used to wash down food? Yes _______ No _______
12) Does your child tip their head forward to swallow? Yes _______ No _______
13) Does your child tip their head backward to swallow? Yes _______ No _______
14) Does your child tip their head sideways to swallow? Yes _______ No _______

Observe and record your findings hee and on the "7-Day Diet" Log sheet attached. Please return this form and the completed log during your child's evaluation or within 7 days.

We can then discuss increasing / decreasing textural demands and proper chewing habits the child can develop while acknowledging their taste preferences.

Thank you for your help and cooperation in this task.

7-DAY DIET LOG

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Parents :: Please keep a 7-day diet log on this page. Write down everything your child will and will not eat for each meal and snack for 7 days. Answer the yes / no questions on the first page. Please return this finished log and the completed introduction page at their initial evaluation or within 7 days. Thank you for your help!

	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
BREAKFAST							
LUNCH							
SNACK							
DINNER							
SNACK							

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HOME OBSERVATION CHECKLIST

Name: ______________________________ Date: _________________________

Please check all that apply within the next 48 hours ☺

1) Usual position of the lips and teeth during daytime.

- ❒ Open wide
- ❒ Open slightly
- ❒ Closed
- ❒ Lips closed, but jaw position is low
- ❒ Lips closed, but strong contraction of the chin and lip muscle
- ❒ Teeth positioned over the lower lip

2) Usual position of the tongue, lips and teeth during sleep

- ❒ Lips slightly parted
- ❒ Lips apart, tongue showing
- ❒ Mouth breathing
- ❒ Lips Closed

3) Chewing patterns

- ❒ Chews with lips open
- ❒ Chews with excessive lip and chin movement
- ❒ Chews with lips closed
- ❒ Noisy chewing, smacking
- ❒ Forward thrusting of tongue during chewing
- ❒ Reaching out with tongue to meet food or liquid
- ❒ Touching of teeth to utensil, cup or glass
- ❒ Excessive crumbs around mouth and frequent lip licking
- ❒ Mustache after drinking
- ❒ Large bites
- ❒ Fast chewing
- ❒ Slow Chewing

4) Usual position of the tongue during daytime

- ❒ Protruding between both teeth and lips
- ❒ Protruding slightly between teeth
- ❒ Low positioned, pressing against lower teeth
- ❒ Unobservable, lips closed

5) Sleeping posture

- ❒ Back
- ❒ Left Side
- ❒ Right Side
- ❒ Stomach (face left/right side)

6) Oral habits

- ❒ Thumb or finger sucking
- ❒ Tongue sucking
- ❒ Lip Biting
- ❒ Lip licking (chapped lips)
- ❒ Pencil biting
- ❒ Finger nail biting
- ❒ Mouth breathing
- ❒ Tooth grinding (bruxing)
- ❒ Drooling
- ❒ Facial, tooth, head or neck pain

7) Day time body posture

- ❒ Poor
- ❒ Average
- ❒ Good
- ❒ Face Leaning
- ❒ Chin Leaning
- ❒ Phone resting on shoulder

Additional comments?

MYOFUNCTIONAL THERAPY APPROACH

We prefer to use a positive approach to eliminate such oral dysfunctions as mouth breathing, open mouth posture with lowered tongue position, and tongue thrust by strengthening the muscles of the facial network. This is a psychophysiologic approach which is aimed at coordination of muscle groups as routine for normal deglutition and articulation from a positive reinforcement exercise regimen.

Therapy is an eight-step program (not necessarily an eight-week program):

1) Directed at the tip of the tongue, establishing the placement of the tongue to achieve a labioglossal seal.
2) Aimed at strengthening the musculature that elevates and supports anterior tongue segments
3) Repositioning posterior tongue for resting and for speech.
4) Integration of new swallow with correct resting posture of the anterior segment of the tongue.
5) Establishing new patterns of deglutition on a conscious level.
6) Establishing new patterns for subconscious control of chewing, swallowing and tongue resting position.
7) Determination of the correct subconscious tongue position for resting posture.
8) Final concerns and evaluation of total pattern of facial musculature.

Recheck at any change in oral environment: Bands off, retainer, extractions, etc., or if the referral source desires. Patient is dismissed from therapy when at least one recheck, after a three month lapse, demonstrates correction and proper use of muscles to the complete satisfaction of clinician and patient.

Speech Solutions
Speech Therapy & Orofacial Myology

NOTICE OF THE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. We are required by federal law to maintain the privacy of your Protected Health Information, and to provide you with notice of our legal duties and privacy practices regarding Protected Health Information. "Protected Health Information" is information that we keep in electronic, paper or other form, including demographic information collected from you and is created or receive by us relates to your past, present, or future physical or mental health condition, the provision of health care services to you or the past, present, or future payment for the health care services we deliver to you, and that identifies you or which we reasonably believe can be used to identify you. We are required by federal law to comply with the terms of this notice. We reserve the right to make changes in our privacy practices regarding your protected health information. If we change our privacy practices, which change will apply to all protect health information that we maintain about you. However, before we change our privacy practices, we will provide you with written notice of any changes. We may use and disclose your Protected Health Information for a variety of purposes. For example:

1) Treatment: We may disclose you protected health information to another physician, such as a specialist, to whom we refer you for medical treatment. THE FOLLOWING AUTHORIZES Speech Solutions TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATION:
    a. I give permission to Speech Solutions to use my name, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related email messages, text messages, and information about treatment alternatives or other health related information.
    b. I give permission to Speech Solutions to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a doctor or assistant in private, the doctor or assistant will provide a private room for these conversations BY APPOINTMENT ONLY. By signing the following, you are giving Speech Solutions permission to use and disclose your protected health information in accordance with the directives listed above.
2) Health Care Operations: We may disclose your protected health information to a health plan, managed care plan, individual practice association or to a management services organization that analyzes our delivery of medical services to evaluate our health care quality management, case management or professional competence. We may also provide your protected health information to other health care providers, such as laboratories or ambulance companies, for purposes of their health care operations.
3) Payment: We may disclose your protected health Information to obtain payments. Disclosures for "payment" include: a) disclosure to a health plan to determine your eligibility or coverage under the plan; b) billing services or collection agencies, c) disclosures to billing services or collection agencies, d) disclosures for utilization management and determinations of whether the medical service we deliver to you are necessary or appropriate, or e) disclosures to determine whether the amount we charge you for medical services are justifiable.

4) Reminders and Treatment Alternatives : We may contact you to provide you with appointment reminders or information about medical treatment alternatives or other health\related benefits and services that may be of interest to you.

We may use or disclose your protected health information in connection with treatment, payment, or health care operations we deliver health care products or services to you based on the orders of another health care provider, and we report the diagnosis or results associated with the health care services directly to another health care provider, who provides the products or reports to you. We may use or disclose your protected health information that was created or received in emergency treatment situation, to carry out treatment, payment, or health care operations if we attempt to obtain your consent as soon as reasonably practicable after the delivery of such treatment.

We may disclose your protected health information without your authorization in the following circumstances: a) for public health activities, such as controlling communicable diseases, reporting child abuse or neglect, to monitor or evaluate the quality, safety or effectiveness of FDA\related products or services, b) for reporting victims of abuse, neglect or domestic violence, c) for health oversight activities, such as overseeing government benefit programs, d) in response to judicial or administrative orders, such as subpoenas, 3) for law enforcement purposes, such as mandatory reporting of certain types of wounds, or identifying or locating individuals, f) for certain research purposes, g) to avert a serious threat to the health or safety of an individual or the general public, and H) for selected governmental function, such as national security. In each of these situations we will keep records that explain our attempt to obtain your consent and the reason why consent was not obtained.

We are required to disclose your protected health information: a) to you upon your request; and b) to the US Department of Health and Human Services (“DHHS”) when DHHS investigates to determine whether we are complying with federal law.

We may disclose your name, your location in our facility, your general condition and your religious affiliation, if any, in our facilities directory, unless you object verbally or in writing.

In all other circumstances we must obtain your authorization to use or disclose your protected health information. You will be required to sign an authorization form which permits us to use and disclose your protected health information for certain purposes, and we may not condition the delivery of medical treatment to you on your providing the requested written authorization. You have the right to revoke our authorization in writing as long as we have not acted in reliance on the authorization.

You have the following rights with respect to your protected health information:

1) The right to request restrictions on our use and disclosure of your protected health information for treatment, payment or health care operations. If we agree to any restriction, then we cannot violate that restriction except in the case of emergency treatment. However, we are not required to agree to any restrictions.
2) The right to request in writing and to receive confidential communications of your protected health information by alternative means (such as by mail or email) or alternative locations (such as your office or business workplace).
3) The right to request in writing access to our office to inspect and copy your protected health information. Except in cases where the protected health information is not maintained or accessible on\site, we will act on a request for access no later than thirty (30 days after we receive our request.

4) The right to request in writing that we amend your protected health information. Your request must contain the reasons to support the requested amendment. We will act upon your request within sixty (60) days after we receive your requested.
5) The right to receive an accounting of all our disclosures of your protected health information in the six years prior to the date of your request, except for disclosures (A) to carry out treatment, payment and health care operations, b) to you, c) for your directory or to persons involved in your care, d) for national security or intelligence purposes, e) to correctional institutions or law enforcement officials, 1) pursuant to any written authorization that you give to use, or g) that occurred prior to April 14, 2003.
6) The right to request and obtain from us a paper copy of this notice. If you believe that we have violated your privacy rights, then you may file a written complaint with Carolinda T. Myers-Murphy, MS CCC\SLP who is our privacy officer. You may also file a complaint with the Office for Civil Rights of the DHHS. Your complaint must: a) be in writing, either on paper or electronically, b) name the company and describe the acts or omissions you believed to be in violation of the privacy rules, c) be filed within 180 days of when you knew or should have known that the act or omission complained of occurred unless the time limit is waived by the DHHS for good cause shown. The complaint may be sent to : Office of Civil Rights, US Department of Health and Human Services, Region IX, 50 United Nations Plaza, Room 322, San Francisco,, CA 94102. We will not retaliate against you for filing a complaint. If you wish to obtain additional information about any of the matters discussed in this notice, you may contact Carolinda T. Myers-Murphy MS CCC\SLP at (808) 596.0099.

This notice is effective as of November 11, 2009.

____ ________________________

Signature of Patient and / or Guardian Date

____

Printed Name of Patient and/or Guardian

ACKNOWLEDGEMENT OF RECEIPT & NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures: I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health care information for directory purpose.
- The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations.

____ ________________________

Signature of Patient and / or Guardian Date

____

Printed Name of Patient and/or Guardian

Speech Solutions
Speech Therapy & Orofacial Myology

PERMISSION FOR EXCHANGE OF INFORMATION, RECEIPT OF HIPPA

I give permission to exchange medical information, either written or by phone, between my providers of medical and therapeutic services (or those of my child), as well as insurance providers. I understand that the purpose of this exchange is to allow for coordinated services between these providers. I have received the HIPPA information and understand its contents in its entirety.

____ ____________________

Signature of Patient and / or Guardian Date

____

Printed Name of Patient and/or Guardian

PERMISSION TO USE FILES FOR RESEARCH OR PRESENTATION

I give my permission for use of photographs and records made in the process of examination and treatment, to be used for the purposes of research, education and publication in professional journals.

____ ____________________

Signature of Patient and / or Guardian Date

____

Printed Name of Patient and/or Guardian

Success of Therapeutic Program

"It must be noted that successful completion of the myofunctional therapy program is dependent upon patient desire, good attitude and self-discipline. Parental involvement and encouragement are important and necessary. Only the dedicated participant and cooperation of the patient can guarantee effective swallowing and resting posture results."

Airway Problems and Their Affects

In order to be successful in this program, the patient must achieve closed mouth resting posture. A clear airway is necessary in order to reach this goal. Patients who have allergies or related nasal airway problems present a high risk that goals will not be attained or may require additional visits to do so.

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Honolulu, HI 96813
(808) 596-0099
www.speechsolutionshawaii.com

RELEASE AND HOLD HARMLESS

I do hereby release and agree to indemnify, protect and hold harmless, Speech Solutions; LLC and its therapists and volunteers, and all private persons or organizations providing services for Speech Solutions; LLC from any claim or liability whatsoever, including, but not limited to, personal injury, death, property damage, court costs, attorney fees and interest, however caused, including the negligence of Speech Solutions; LLC, as a result of the clients participation in activities.

____ ______________________
Signature of Patient and / or Guardian Date

____
Printed Name of Patient and/or Guardian

Speech Solutions
Speech Therapy & Orofacial Myology

POLICY :: PARENT PRESENCE DURING SPEECH THERAPY SESSIONS

Infants and toddlers with impairments requiring speech therapy also require an alliance between the parents and therapist. Most therapy sessions include demonstrations of techniques to parents so that they can follow through with observed and recommended activities. Your child requires your assistance in order to progress.

If you work full-time and have a regular child care provider, you may provide permission for your child care provider to be present in your place for some of the speech therapy sessions.

We will make every effort to schedule sessions for a time that is convenient to one or both parents and when your child is most ready to work.

We are not affiliated with a Home Health Care Agency and so if your child receives Home Health Care nursing services, you should understand that we do not have a contractual relationship which would allow us to extend services through nurse care providers who are not related to your child. Nurse care providers are certainly welcome to be present and observe therapy sessions and they can follow through with any recommended activities that you request. Nurse care providers cannot be a substitute for your presence.

We understand the challenges related to meeting scheduled appointments. If you cannot be present for you child's speech therapy session please cancel your appointment within 24 hours of the scheduled time, and please refer to our cancelation policy to see how this may affect you.

You may call and leave a message at (808) 596-0099

I have read and understood the policy regarding parent's presence during speech therapy sessions.

____ ____________________
Signature of Patient and / or Guardian Date

I give __________________________ permission to attend speech therapy sessions with my child when neither of his/her parents are available to attend. Speech Solutions, LLC has my permission to share any relevant medical information necessary to provide service and instruct my representative in home exercise programming.

____ ____________________
Signature of Patient and / or Guardian Date

____
Printed Name of Patient and/or Guardian

Speech Solutions
Speech Therapy & Orofacial Myology

Initial Screening Fee	$55.00 per screening. An initial consultation is warranted to determine what type of evaluation would be most appropriate for you or your child.
Speech/Language Evaluation Fee **Orofacial Myology Evaluation Fee**	$62.50 / 15 minute segment per Senior Speech Pathologist $50.00/ 15 minutes segment per Staff Speech Pathologist An initial evaluation may involve some or all of the following elements: • The taking of a detailed case history • Counseling (according to the patients emotional needs) • Determination of options for ongoing management following assessment • Consideration and implementation of appropriate treatment • Administration of standardized clinical assessment or an empirical clinical assessment • Assessment of the ability of the patient to communicate at the persons school or workplace • Evaluation and analysis of the assessment results • Time spent writing an evaluation report
Assessment Report	$49.00 for an electronic or hard copy of the assessment report
Private Speech/Language/OFM Therapy Fee	$125 / session with a Senior Speech Pathologist $110 / session $ 69 / OFM therapy session
Group Therapy Rates	$60 / per student/hour: Group of 2 $50 / per student/hour: Group of 3
Travel Fee	$1.25 per minute of travel time from the therapist's current location to your location and back. Travel may be used for the purposes of a) Case conference, or b) A home, hospital, or worksite visit, or c) Therapy/consultation where the patient is otherwise unable to attend sessions in the speech therapy clinic or rooms.
Consultation Fee	Meetings or phone conferences will be charged a consultation fee at the speech/language therapy rate. This includes but is not limited to meetings with a client or responsible party, outside therapist, school representative, physician and/or attorney/advocate, during testimony at legal proceedings. Time spent reviewing any outside documentation will be charged at the therapy rate.
Paperwork Fee	Any paperwork requested by the client will be charged a paperwork fee at the speech/language therapy rate. (i.e., may include but not limited to time spent writing an evaluation report, or progress report).
Bad Check Fee	$45.00 in addition to your last statement fee will be applied.

** All charges and rates detailed above are subject to review. Therapy Sessions are approximately 45-60 minutes long depending on an individuals' ability to tolerate the goals targeted.
* There is no direct billing to insurance companies except for Tri-Care patients. Payment is conducted in advance by Credit Card only on the 1st of each month prior to therapy. An official invoice will be issued before payment is collected and can be submitted by the client for reimbursement through an individual's health plan coverage.

PATIENT RESPONSIBILITIES

Patients (or legal guardians/caregivers) will automatically be charged on their credit card on the 1st of each month for their scheduled therapy sessions. If a patient cancels a therapy session, they have within the current billing cycle to make up the therapy session without penalty, *and is subject to availability*. (i.e., if you cancel an appointment in September, it must be made up before October 1st). If a patient cancels less than 7 days prior to the 1st of the month, they will have 7 days to reschedule a missed appointment. (i.e., if you cancel on the 9/28, then you will have until 10/5 to reschedule). Parents should notify us of any known schedule conflicts before the 1st of the month in order to avoid a charge. **If a patient is unable to reschedule before the next billing cycle, the amount applied towards the canceled therapy session is not reimbursable.** I further understand that Speech Solutions reserves the right to change our therapy schedule should we miss 3 appointments in a 1-month period. A patient (or legal guardian/caregiver) will be responsible for all uncovered costs, including but not limited to: speech/language services and any additional charges explained above. I have read, understood and agree to the terms and policies of Speech Pathology of Hawaii; LLC (DBA: Speech Solutions).

________________________________ ____________________
Signature Date

SPEECH SOLUTIONS
Speech Therapy & Orofacial Myology

CREDIT CARD AUTHORIZATION

Please complete the following to authorize the charge to your credit card

NAME ON CARD: ______________________________

MAILING ADDRESS: ______________________________

CARD NUMBER: ______________________________

TYPE OF CARD: ______________________________
(NOTE: We accept MasterCard, Visa, and Discover, NOT AMEX)

EXPIRATION DATE: ______________________________

SIGNATURE: ______________________________

DATE: ______________________________

TELEPHONE #: ______________________________

COMMENTS: ______________________________

____

TRICARE AUTHORIZATION

For patients with Tricare insurance only. Please fill out the following information so we can bill Tricare for services.

SPONSOR SSN: ______________________________

CHILD'S BIRTHDATE: ______________________________

*Note: We require a paper copy of your Tricare authorization, made out to Speech Pathology of Hawaii, in hand **before** services can be rendered. This can either be faxed to 1-888-331-0723, or emailed to admin@speechsolutionshawaii.com. We reserve the right to cancel any evaluation or therapy session if prior authorization is not secured. For patients with Tricare Standard, please talk to our billing department prior to your evaluation to confirm self-referral status. Any services not paid are the responsibility of the parent / patient. If the evaluation is denied by Tricare, you will need to follow up with Tricare directly to request payment.*