Stephen P. Zieniewicz, FACHE
President and Chief Executive Officer

Thank you for scheduling an Evaluation at the RWJBarnabas SBMC Adult and Pediatric Speech Center on:

____

We are located at:
375 Mount Pleasant Avenue
West Orange, NJ Suite G100

WELCOME TO THE RWJBarnabas SBMC ADULT AND PEDIATRIC SPEECH CENTER

We have created an outline of topics that pertain to your visit. Please feel free to call us at any time at 973-969-3434 for further details, or with questions or concerns.

INSURANCE CO-PAYMENTS

Co-pays are collected at the time of each visit. We are sorry, but **we cannot bill for insurance co-pays**.

INSURANCE COVERAGE

Our office staff will call your insurance provider on your behalf to determine **eligibility** for coverage of our services. **This is not a guarantee of payment for services provided. Any costs not covered by your insurance plan will be billed to you and will be your responsibility**. Please note that co-insurance and deductible amounts are individual to each plan and are your responsibility.

THERAPY PRE-CERTIFICATION

Each insurance carrier has different criteria for pre-authorization or pre-certification of evaluations and therapy. The staff member that will be working on your behalf to obtain this authorization will let you know how long they anticipate this process will take. In some cases it may take several attempts and several weeks to complete the process.

INSURANCE REFERRALS

Referrals are **required** at the time of the visit. If your referral is not available prior to your appointment time OR securing the referral from your Primary Care Physician causes a delay in the processing your registration, there may be a delay in being seen by the speech pathologist. If you are unable to secure the referral for the day of the appointment, you may be asked to reschedule your appointment.

Saint Barnabas Medical Center | RWJBarnabas HEALTH

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PHONE SYSTEM

The main number to our Center is 973-969-3434. Phone calls are answered by our staff during regular office hours. If you call the office after regular hours, you can leave a message on our after-hours line. Any message that is left after hours will be returned on the next business day. Please be sure to leave the patient's name and a phone number on the message. Please call the main number if you anticipate a delay in your arrival to the center for your appointment.

PATIENT CONFIDENTIALITY

You may be asked to complete registration paperwork prior to arriving to your initial visit. In addition, we will ask each patient to update paperwork at the beginning of each calendar year. The information that is contained in the patient chart is kept confidential. We require that each patient/guardian sign a HIPAA release form that gives us permission to release pertinent information to your PCP and to anyone that you specifically identify. We will only release information to people or places that you specifically give permission for us to do so. Please note that any patient **under the age of 18 years** must be accompanied by a guardian.

WAIT TIME

Waiting in the office is always an inconvenience, especially when you are waiting with a young child. We apologize if your appointment is delayed for any reason. Please understand that there may be a patient that requires additional time spent with the speech pathologist that you are waiting to see. You will be offered the same consideration of adequate time.

MISSION

We strive to provide outstanding comprehensive care to all of our patients. Once a plan is set in place for each patient, we are committed to monitoring and following up on your progress. **You may receive a patient survey in the mail or via email following your visit to our center. Please take a moment to complete and return it, as we value your input.**

Sincerely,

Randi Schwartz-Zalayet, MS, CCC-SLP
Supervisor

375 Mount Pleasant Avenue
Suite G100
West Orange, NJ 07052

973.969.3434

barnabashealth.org/sbmc

Saint Barnabas Medical Center | **RWJBarnabas HEALTH**

Name ____________________

D.O.B. ____________________

SUMMARY LIST
Speech Therapy
Adult

Initial Visit Date: ____________________

Referring MD: ____________________ Primary MD: ____________________

Patient Problem (chief complaints): ____________________

Height: __________ Weight: __________ N/A: __________

Allergies/Adverse Allergic Drug Reactions (Note symptoms exhibited): ____________________

Please check all significant medical diagnoses and conditions: ☐ **No significant medical history**

Diagnosis/Condition	Date	Diagnosis/Condition	Date
☐ Cancer Type:		☐ Multiple Sclerosis	
☐ Diabetes		☐ Seizures	
☐ High Blood Pressure		☐ Infectious disease (TB / Hepatitis / MRSA)	
☐ Heart Disease		☐ Skin conditions	
☐ Angina/chest pain		☐ Polio / post polio	
☐ Deep Vein Thrombosis		☐ Urinary incontinence	
☐ Pacemaker		☐ Depression	
☐ Stroke		☐ Sleep disorder	
☐ Circulation Problems		☐ HIV positive	
☐ Arthritis		☐ Are you / could you be pregnant	Yes / No
☐ Osteoporosis / osteopenia		☐ Parkinson's Disease	
☐ Lung problems		☐ Other	
☐ Asthma		☐ Other	

Please list all significant surgical/invasive procedures:

Procedure	Date

Current medications should include prescribed and over the counter medications, herbal medications and supplements: ☐ No medications at this time _____ / _____ / _____

MEDICATION/VITAMINS/SUPPLEMENTS	DOSE	FREQUENCY	ROUTE

Saint Barnabas Medical Center | **RWJBarnabas HEALTH**

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Cognitive-Communicative Assessment Intake Form

Thank you for scheduling your evaluation at RWJBarnabas Health. Please take a few minutes to fill out this form and bring it with you to the evaluation.

Name ______________________ **Date of Birth**__________________
Age_______ **Date of Evaluation**______________

Gender __**male** __**female** __**transgender male** __**transgender female** ___**additional category** __**decline**

Address______________________ **Phone**______________________
______________________ **Cell**______________________
______________________ **E-mail**______________________

Primary Language ____
Languages spoken ____

Primary Physician______________ **Referring Physician**______________
Phone______________________ **Phone**______________________
Address ______________________ **Address** ______________________
______________________ ______________________
______________________ ______________________

Medical Diagnosis____

Onset date of the Problem (Date) ____

Nature of the Problem ____ Stroke ___TBI ____Parkinson's Disease ___ALS ____ Multiple Sclerosis
_____ Head/Neck Cancer ____Concussion ____Other

I am experiencing difficulty with: **please check all that apply**
__ Immediate memory ___ Short term memory ___Long term memory ___Attention/Concentration
__ Orientation (time/surrounding) ___Problem Solving ___Thought organization
__ Deductive reasoning ___ Processing of information ___ Speed of Processing ___ Word Finding

I am experiencing difficulty in the following settings: **please check all that apply**

___School ____Engaging with family/friends ___Work ____Driving ___Hobbies/Interest

How are your current deficits affecting you in social situations?______________________
____
____

Occupational History
Student____
Employed ____
Retired ____
Unemployed ____
Cognitive Communicative skills required at work/school______________________

Highest Level of Education:
___Current Grade level ___High School Diploma ____College Degree ___Masters Degree ___(other)

Do you have a history of any behavioral or mental health? __Yes __No
If "Yes" Please describe ____
____

Do you currently have any behavioral or mental health? __Yes __No
If "Yes" Please describe____
____

Have you received speech therapy/cognitive therapy in the past? __Yes __No
If "Yes" for what reason ____
____

Do you/have you received any other therapy in related to your current problem? __Yes __No
If "Yes" what therapist and for what reason________________________________
____

For patients currently in school:
Current school/grade____

Do you have a history of learning disabilities? __Yes __No

If "Yes" what is your diagnosis____

Do you receive services in school (IEP or 504 plan)? __Yes __No

If "Yes" what services do you receive?_____________________________________

Do you engage in extra curricular activities (i.e. clubs, sports, etc)? __Yes __No
If "Yes" please describe ____
____
If "Yes" and you play a sport have you been cleared to return?
__Yes __No __Practice Only ___With restrictions

Please list two or three goals you would like to achieve.
1) ____
2) ____
3) ____

Please list any questions/concerns you have for the therapist.
1) ____
2) ____

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COMPREHENSIVE OUTPATIENT REHABILITATION CENTER
CANCELLATION / NO SHOW POLICY

Research has demonstrated that for rehabilitation therapy to be effective and efficient, it is essential to have patients compliant with their scheduled plan of care. Those patients who are compliant with their schedule and home exercise program achieve their functional goals more efficiently. Due to the high volume and our expanding waiting list for patients, SBMC is adjusting the cancellation policy.

- **If you are more than 15 minutes late, we may need to reschedule your appointment.** Therapy sessions average minutes per session, depending on your treatment plan. It is important to your progress that you arrive on time so that we may provide you with the most efficient and effective quality care.

- **If you need to cancel or reschedule an appointment, please call us at (973) 969-3434, with at least 24 hours' notice.** If you have transportation issues and or concerns, please let your therapist know, so that a realistic care plan can be established.

- **If you cancel with less than 24 hours' notice on 2 occasions, do not show for 2 appointments, or miss more than 50% of visits, we reserve the right to cancel future appointments.**

We are committed to your care, and your progress is dependent on consistency and continuity of care. Your safety is important to us. Any weather related cancellations would not be subject to this cancellation policy.

Thank you for choosing RWJBarnabas Health for your care.

Dr. Charles Curtis, PT, DPT, Cert MDT Physical Therapist
Director of Comprehensive Outpatient Rehabilitation Services

Date: ______________________________

____
Patient signature

375 Mt. Pleasant Avenue
West Orange, NJ 07052

973.969-3434

rwjbh.org/acc