

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.

375 Mount Pleasant Avenue
Suite G100
West Orange, NJ 07052

973.969.3434

barnabashealth.org/sbmc

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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
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West Orange, NJ 07052
973.969.3434

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

Please list all significant surgical/invasive procedures: _____ **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

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Speech-Language Adult 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 <input type="checkbox"/> male <input type="checkbox"/> female <input type="checkbox"/> transgender male <input type="checkbox"/> transgender female <input type="checkbox"/> additional category <input type="checkbox"/> decline	
Address _____	Phone(h) _____ (w) _____
_____	Cell _____
_____	E-mail _____
Primary Language _____	
Languages spoken _____	
Primary Physician _____	Referring Physician _____
Phone _____	Phone _____
Address _____	Address _____
_____	_____
_____	_____

Have you received any previous evaluations or therapy for your current concerns? Yes No
If "Yes" for what reason and where _____

Are you currently receiving any other therapy? Yes No
If "Yes" what therapy and for what reason _____

Chief Complaint (Language): I am experiencing difficulty with: **please check all that apply**
 Receptive language skills Expressive language skills Word finding/thought organization
 Writing Reading None

Chief Complaint (Speech): I am experiencing difficulty with: **please check all that apply**
 Fluency/Stuttering Articulation/Pronunciation Coordination/Motor planning
 None

Chief Complaint (Cognitive): I am experiencing difficulty with: **please check all that apply**
 memory attention processing skills problem solving
 safety judgments organization None

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 environments? _____

Do you experience any difficulty with swallowing? ___ Yes ___ No

Occupational History:

Employed (specify occupation) _____

Retired _____

Unemployed _____

Highest Level of Education:

Current Grade level _____ High School Diploma _____ College Degree _____ Masters Degree _____ (other)

Focus of study _____

Family History:

___ Single ___ Married ___ Widowed ___ Divorced ___ domestic partnership

Spouse's Name _____

Children's Name(s) _____

Patient Residence:

Who do you reside with? _____

Social History:

Do you drink alcoholic beverages? ___ yes ___ no If "yes" how frequently? _____

Do you smoke? ___ yes ___ no If "yes" how frequently? _____

Hobbies/Interests _____

What goals would you like to achieve in therapy? _____

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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