LIFESPAN THERAPY
Speech • Language • Cognition • Swallowing

Lifespan Therapy PLLC
4020 Hendersonville Rd. Suite E
Fletcher, NC 28732
P: 828-222-4875
F: 828-222-7110

INTAKE FORM

Patient's Legal Name: _____ Date of Birth:____/_____/_____

Sex: ☐ **M** ☐ **F** Email: _____

Parent/Guardian Names: _____

Address: _____

City/State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

PCP/Pediatrician Name: _____ Office Name: _____

Medical History/Complications: _____

_____

Previous speech therapy: ☐ **Y** ☐ **N** Please explain: _____

_____

Current main concerns:

_____

_____

_____

_____

_____

_____

_____

_____

How did you hear about us? ☐ Doctor ☐ Family/Friend ☐ Social Media ☐ Internet Search

If your therapist is unavailable, are you willing to see another associate at Lifespan Therapy? ☐ Yes ☐ No

Are you receiving any of the following services?

☐ Home Health Care (Nursing or Therapy) ☐ Hospice ☐ Speech therapy from another provider ☐ None

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PRACTICE POLICIES

Appointments & Cancellations
Sessions are typically 30 minutes; changes must be arranged in advance. A $25 fee applies for cancellations/reschedules made with less than 24-hour notice. First late cancellation/no-show will be waived. Consistent attendance is required for progress; clients may be discharged after 3 consecutive cancellations/no-shows or at the SLP's discretion for poor attendance. Late arrival may reduce session time.

Telephone & Accessibility
You may contact us via text or voicemail; messages are returned within 24 hours. Teletherapy may be offered if you are sick, out of town, or need extra support. In an emergency, call 911.

Electronic Communication
We use HIPAA-compliant methods (email, text, phone, portal, fax). Email/text may be used for scheduling only—therapeutic content or emergencies should not be communicated this way.

Minors
Parents/guardians may have legal rights to treatment information. Children must be supervised in the waiting area; Lifespan Therapy is not responsible for unattended minors. Please use caution near doors when exiting.

Termination
Therapy may be ended if treatment is not effectively used, if attendance/payment is inconsistent, or at the client's request. A termination process will be discussed, and referrals to other providers will be offered. If no appointments are scheduled for 3 consecutive weeks (without prior arrangements), the professional relationship will be considered ended.

Consent for Treatment & Telehealth

I consent to evaluation and treatment for myself and/or my child by Lifespan Therapy, PLLC under the direction of a certified Speech-Language Pathologist. I understand that I can ask questions at any time regarding treatment. A parent/guardian must be present during sessions.

I authorize release of necessary information to my insurance company for billing. I understand I am responsible for any charges not covered by insurance, due at the time of service.

I understand telehealth sessions may be conducted via Zoom. Telehealth offers convenience and access to care but may have risks (technical issues, unauthorized access). Zoom is not an emergency service; in an emergency, I will call 911. I agree not to share my session link with others.

By signing, I acknowledge I have read, understood, and agree to these policies.

Patient/Guardian Signature: _____ Date: _____

Patient Name: _____

Parent/Guardian Name: _____

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INSURANCE ACKNOWLEDGEMENT

Primary Insurance Information

Insurance Name:

Policy Number:

Group Number:

Primary Insured Name (if not the client):

Primary Insured Social Security Number (if not the client):

Primary Insured Date of Birth (if not the client):

Client Social Security Number:

Secondary Insurance Information

Insurance Name:

Policy Number:

Group Number:

ASSIGNMENT OF INSURANCE BENEFITS

As a courtesy, we will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If you do NOT provide this insurance information prior to your visit, we will not file the insurance on your behalf retroactively. If some fees are not paid by your plan, you will be responsible for any unpaid deductibles, co-payments, or coinsurance as allowed by the insurance contract.

Verification of eligibility and/or benefit information is not a guarantee of payment. Benefits will be determined once a claim is processed and will be based upon, among other things, the member's eligibility. Any claim received during the interim period with the terms of the member's certificate of coverage is applicable on the date services were rendered.

I hereby assign benefits to be paid, on my behalf, to Lifespan Therapy, PLLC. I understand and agree to be financially responsible for charges not paid within a reasonable time by insurance or another third-party payer. I certify the information given regarding insurance coverage is correct and active.

Patient/Guardian Signature: _____ Date: _____

Patient Name: _____

Parent/Guardian Name: _____