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 & Attendance

Sessions are typically 30 minutes; schedule changes must be arranged in advance. A $25 fee applies for cancellations or reschedules made with less than 24 hours' notice. The first late cancellation or no-show may be waived at the discretion of Lifespan Therapy, PLLC.

Consistent attendance is required to support therapeutic progress and maintain your reserved appointment time. Due to high demand, repeated missed appointments, late cancellations, or inconsistent attendance may result in modification or loss of your scheduled time and/or discharge from services at the discretion of Lifespan Therapy, PLLC. A pattern may include, but is not limited to, three (3) or more late cancellations and/or no-shows within a 60-day period or multiple consecutive missed appointments.

Late arrival may result in reduced session time.

Communication & Accessibility

You may contact us via text or voicemail; messages are typically returned within 24 hours. We use HIPAA-compliant methods (email, text, phone, portal, fax). Teletherapy may be offered as appropriate. Email and text communication are for scheduling purposes only and should not be used for clinical or emergency concerns. In an emergency, call 911.

Minors

Parents/guardians may have legal rights to treatment information. Children must be supervised at all times in the waiting area. Lifespan Therapy, PLLC is not responsible for unattended minors.

Termination

Services may be discontinued if treatment is not effectively utilized, if attendance or payment is inconsistent, or at the client's request. Due to high demand, failure to maintain consistent attendance may result in discharge. If no appointments are scheduled for three (3) consecutive weeks without prior arrangements, the professional relationship will be considered ended. Referrals will be provided as appropriate.

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. A parent/guardian must be present during sessions.

I authorize the release of necessary information for billing purposes and understand that I am financially responsible for all charges not covered by insurance, due at the time of service.

I understand that telehealth services may be provided via electronic platforms (e.g., Zoom), which may carry risks such as technical issues or unauthorized access. Telehealth is not an emergency service; in an emergency, I will call 911. I agree not to share session access information with others.

By signing below, I acknowledge that I have read, understand, 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, Lifespan Therapy, PLLC will bill your insurance plan for covered services if we are a participating provider. Verification of benefits is not a guarantee of payment. Coverage and payment are determined by your insurance carrier at the time claims are processed.

I am responsible for providing accurate and current insurance information prior to services. Failure to do so may result in denial of claims, and services will not be billed retroactively. I understand and agree that I am financially responsible for all charges not paid by my insurance, including but not limited to deductibles, co-payments, and coinsurance, as determined by my insurance plan.

I hereby assign insurance benefits to be paid directly to Lifespan Therapy, PLLC.

Card-on-File Authorization

I understand that I may provide a credit/debit card to be securely kept on file for convenience. By signing below, I authorize Lifespan Therapy, PLLC to charge this card for any patient-responsibility balances (e.g., deductibles, co-payments, coinsurance, or denied claims) after insurance processing, unless alternative payment arrangements are made in advance.

I understand I may request removal of my card on file at any time.

Patient/Guardian Signature: _____ Date: _____

Patient Name: _____

Parent/Guardian Name: _____

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Self-Pay Agreement for Services

Patient Name: _____ Date of Birth:_____

Parent/Guardian (if applicable): _____

Fee Schedule
The following fees apply to services provided:

Evaluations: $250 - Consults: $50 - Re-assessment report writing: $50

30 mins session: $85 - 45 mins session: $135 - 60 mins session: $180

Self-Pay Acknowledgment

I understand that Lifespan Therapy, PLLC does not bill insurance for these services and that I am solely responsible for full payment at the time of service unless prior arrangements are made. Payment is required regardless of insurance coverage, reimbursement eligibility, or claim denial. I may request a superbill for independent submission to my insurance; reimbursement is not guaranteed.

Accepted forms of payment include credit/debit card, HSA/FSA card, cash, or check.

Card-on-File Authorization

By signing below, I authorize Lifespan Therapy, PLLC to securely store my credit/debit card on file and to charge this card for services rendered, including evaluations, treatment sessions, late cancellations/no-show fees, and any outstanding balances. Charges may be processed on the date of service or within a reasonable timeframe thereafter.

I agree to maintain a valid payment method on file. If a payment is declined, I agree to provide updated payment promptly, and I understand services may be paused until the balance is resolved.

Financial Responsibility

I agree to pay all charges incurred. Lifespan Therapy, PLLC reserves the right to suspend or discontinue services for non-payment.

Patient / Guardian Signature: _____

Printed Name: _____ Date: _____