Coulson & Associates

Client Intake Form

CONFIDENTIAL CONTACT FORM

Full Legal Name: _____ / _____ / _____
Last Name *First Name* *Middle Name*

Preferred Name: _____ Age: _____ Date of Birth: _____

Address: _____ / _____ / _____ / _____
Street #/PO Box *City* *State* *Zip Code*

Telephone: (H) _____ (W) _____ (M) _____

E-mail Address: _____ Gender: Female _____ Male _____

School: _____ Activities/Interests: _____

Skype ID/FaceTime # (If applicable): _____

Who referred you to our office: _____

Reason for visit: _____

If client is a student are you aware that some appointments may infringe on school time? Yes No

RESPONSIBLE PARTY

Full Legal Name: _____ / _____ / _____
Last Name *First Name* *Middle Name*

Address: _____ / _____ / _____ /_____
Street #/PO Box *City* *State* *Zip Code*

Telephone: (H) _____ (M) _____

Occupation: _____ Employer: _____ Work #: _____

Single Married Partnered Divorced Separated

HEALTH HISTORY

Please indicate with an (X) if client has or has ever had any of the following:

YES	NO		YES	NO	
___	___	Allergy to Latex	___	___	Arthritis
___	___	High Blood Pressure	___	___	Asthma
___	___	Nervous Problems	___	___	Hepatitis
___	___	Tonsillitis	___	___	Epilepsy
___	___	Allergies to Medicines/Drugs	___	___	Heart Problems/Murmur

List: _____

Please mark with an (X) if applicable:

Does the client have a tendency toward:

___ Colds

___ Sore Throats

___ Ear Infections

___ Headaches

How often: _____

YES	NO	
___	___	Have the Tonsils and Adenoids been removed? If so, what age? ____
___	___	Does the client have jaw popping and/or pain?
___	___	Does the client ever suck his/her thumb or fingers? If so, what age? ___
___	___	Does the client breathe through his/her mouth while awake?
___	___	Does the client breathe through his/her mouth while sleeping?
___	___	Does the client clench or grind his/her teeth at night?

List any drugs or medications presently being taken: _____
_____

Other pertinent health information: _____
_____

HEALTH CARE PROVIDERS

DENTIST:

Practice Name: _____

Referred by: _____

Phone: _____

ORTHO:

Practice Name: _____

Referred by: _____

Phone: _____

MD:

Practice Name: _____

Referred by: _____

Phone: _____

OTHER:

Practice Name: _____

Referred by: _____

Phone: _____

CONSENT FOR RELEASE OF INFORMATION AND APPOINTMENT REMINDERS

I give permission to exchange medical information, either written or phone, between my providers of medical, therapeutic and insurance services (or those of my child). I understand that the purpose of this exchange is to allow for coordinated services between these providers. I give consent for the use of cell phone voice or text messaging to be used for appointment and such reminders.

Name of Client (printed): _____ Date: _____

Signed (responsible): _____ Date: _____

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: _____ Date:_____

CREDIT CARDHOLDER AUTHORIZATION INFORMATION

TYPE OF CREDIT CARD: VISA MC AMEX DISCOVER

NAME ON CREDIT CARD: _____

ACCOUNT NUMBER: _____

EXPIRATION DATE: _____

CVC CODE: _____

BILLING ZIP CODE: _____

CANCELLATION AND NO SHOW POLICY

By reading each box and signing below, I agree to the cancellation policy and authorized payment of such.

	Clients and or Parents must call the office (**no emails**) at least 24 hours before a scheduled appointment during business hours to notify us of a cancellation or schedule change. Any cancellations or schedule changes made after that time will be charged an **$90.00 fee**.
	Our business hours are as follows: Monday 9-3pm Tuesday –Thursday 7-6pm the office is **CLOSED on Fridays**.
	If you do not call or show for a scheduled evaluation or therapy session you will be **charged the FULL FEE** for the appointment.
	We understand that there are times when advance notification is not possible, and we are willing to work with those who are faced with extraordinary circumstances beyond their control (natural disasters, sudden emergencies, etc.)

If you have any questions regarding our cancellation policy, please feel free to contact us at 303-759-2760

AUTHORIZATION OF CARD USE

I certify that I am the authorized holder and signer of the credit card referenced above.
I certify that all information above is complete and accurate.
I hereby authorize collection of payment for all charges as indicated above including cancellation policy.

SIGNATURE: _____ DATE: _____

INITIAL EVALUATION

1 CLIENT	60 MINUTE EVALUATION	$250
2+ CLIENTS	60 MINUTE EVALUATION	$140/EACH ADDITIONAL CLIENT
3+ CLIENTS	90 MINUTE EVALUATION	$140/EACH ADDITIONAL CLIENT

FOLLOW UP VISITS

1 CLIENT	30 MINUTE FOLLOW UP	$90
2+ CLIENTS	30 MINUTE FOLLOW UP	$60/EACH ADDITIONAL CLIENT
3+ CLIENTS	45 MINUTE FOLLOW UP	$60/EACH ADDITIONAL CLIENT

VIRTUAL EVALUATION

1 CLIENT	60 MINUTE EVALUATION	$350
2+ CLIENTS	90 MINUTE EVALUATION	$240/EACH ADDITIONAL CLIENT

VIRTUAL FOLLOW UP VISITS

1 CLIENT	30 MINUTE FOLLOW UP	$90
2+ CLIENTS	45 MINUTE FOLLOW UP	$60/EACH ADDITIONAL CLIENT

PAYMENT IN FULL IS DUE AT THE TIME OF SCHEDULING!

WE OFFER THE FOLLOWING METHODS OF PAYMENT:

CASH/PERSONAL CHECK/CREDIT CARD (VISA, MC, DISCOVER & AMEX)

INSURANCE

WE DO NOT ACCEPT NOR BILL OR COMMUNICATE WITH INSURANCE COMPANIES. It is the responsibility of the patient/parent to consult their medical insurance company to inquire if you will be reimbursed for Orofacial Myology Therapy services under your specific plan benefits and how to submit your claims.

CANCELLED AND NO SHOW APPOINTMENTS

Completed Credit Card Authorization form required

Appointments cancelled less than 24 hours prior to the scheduled appointment time will be assessed a $90.00 fee for that appointment time. Appointments where a patient does not show OR call for the scheduled appointment will be charged a FULL FEE.

OROFACIAL MYOLOGY is therapy for the muscles of the face, mouth, tongue, lips and supporting structures. Proper muscle function is important to prevent or correct muscle imbalance. Problems associated with muscles imbalance include, but are not limited to, tongue-thrust/posture, mouth-breathing, thumb/finger sucking, short upper or long lower lips, temporomandibular joint dysfunctions (TMD), incorrect bite, improper articulation, upper respiratory tract conditions and digestive disorders. **The number of therapy sessions needed varies greatly, depending on the client's individual case as well as their participation and cooperation in therapy program.** The state of Colorado Regulatory Agencies, Division of Registration and Board of Medical Examiners **do not require or offer** licensure of Orofacial Myologists or Speech Pathologists.

By my signature below I have read and agree to all the above information.

SIGNATURE: _____ DATE: _____

Relationship to Client: _____