clarity
The speech, hearing, and learning center.
Discovering Potential
Empowering Communication
Transforming Lives
29 North Academy Street | Greenville, SC 29601
p 864.331.1400 f 864.331.1416
www.clarityupstate.org

GENERAL INFORMATION

Client Name: _____ DOB: _____ ☐ Male ☐ Female

Address: _____
Street address City State Zip

Home Phone: _____ Work Phone: _____

Email Address: _____
Your information will be kept strictly confidential and not divulged to any third parties.

Occupation: _____ Employer: _____

Employers Address: _____

List members of immediate family: _____

Are there any members of your family who have had a speech, hearing, or learning problem?

_____

Name of person completing form: _____ Relationship to Client: _____

Address: _____
Street address City State Zip

Home Phone: _____ Work Phone: _____

Referral Source: _____

THE PROBLEM:

Describe your problem in detail:_____

_____

When did you become concerned about the problem? _____

_____

What changes have occurred since you first noticed the problem? _____

_____

Have you had any previous help (therapy)? _____

_____

Have you consulted a physician about this problem? _____

If so, list name and address of physician and brief summary of findings: _____

_____

_____

MEDICAL HISTORY:

List any severe childhood diseases and dates of illnesses: _____

_____

Have you ever been seen at Clarity: The Speech, Hearing, & Learning Center before? If so, when?

_____

Current Client Function Questionnaire
Adult- Speech

Client's Name: _____ Age: _____ Date: _____

Please complete the following information by placing a check mark under the category which best represents the answer to each question. Be sure to answer every question. This information will be kept strictly confidential. Your help in answering these five questions will help us to better serve you.

Do You…	**Almost Always (1)**	**Most of the time (2)**	**Usually (3)**	**Seldom (4)**	**Almost Never (5)**
1) Feel your communication difficulties are affecting your job?					
2) Feel your communication difficulties affect your job potential?					
3) Feel your communication difficulties are affecting your personal life?					
4) Fear or avoid new speaking situations?					
5) Find other commenting about your communication difficulties?					

Other Information:

GENERAL FINANCIAL POLICIES

INSURANCE DISCLOSURE:

Please read and sign the following. If you have any questions about this form, please call Clarity's business office at (864) 331-1400.

I understand that I am responsible for contacting my insurance company or primary care physician for authorization of any visits to Clarity before my appointment date. I understand that prior authorization by my insurance company is not a guarantee of payment, and that I am responsible for all costs not covered by my insurance company. These costs include, but are not limited to: service provided which are not covered by my policy, balances after insurance payment, or failure to obtain authorization before my appointment. I understand that I may be required to pay all amounts owed at the time services are rendered.

If there are any changes to you or your child's insurance between now and the time of your appointment, please notify us because your new insurance may not cover your services.

_____ _____

Signature of Patient or Parent/Guardian **Date**

_____ _____

Patient Name **Patients Date of Birth**

I authorize the release of any medical or other information to the insurance company that is necessary to process my insurance claim(s).

_____ _____

Signature of Patient or Parent/Guardian **Date**

LATE CANCELLATION AND NO-SHOW POLICY

If for any reason, you are unable to keep this appointment, we request you call us 24 hours in advance at (864) 33101400 to cancel or reschedule. If two appointments (in any six month time period) are missed or cancelled with less than 24 hour notice, we will reschedule the appointment after a six month waiting period from the time of the missed appointment.