



COOPER & CO.
LANGUAGE AND
SWALLOWING LAB

Patient Demographics

Patient Name: _____

Date of Birth: _____

Parent/Guardian: _____

Address: _____

Phone Number: _____

Email: _____

Emergency Contact/Relationship: _____

Insurance Provider & Member ID: _____

Medical & Developmental History Form

Primary Physician: _____

Medical Diagnoses: _____

Current Medications: _____

Allergies: _____

Previous Speech/Language or Feeding Therapy:

Relevant Birth/Developmental History:

Consent for Evaluation & Treatment

I give permission to **Cooper & Co. Language and Swallowing Lab, PLLC** to evaluate and provide speech-language therapy services as deemed necessary. I understand that treatment goals will be developed and shared with me, and I may revoke this consent at any time in writing.

Signature (Patient/Guardian): _____

Date: _____

Financial Responsibility & Insurance Authorization

I understand that I am financially responsible for all services rendered by **Cooper & Co. Language and Swallowing Lab, PLLC**, including copays, deductibles, or non-covered services. I authorize the release of medical information to process insurance claims and authorize payment of benefits directly to this provider.

Signature (Patient/Guardian): _____

Date: _____

HIPAA Acknowledgment

I acknowledge that I have received a copy of the **Notice of Privacy Practices** for **Cooper & Co. Language and Swallowing Lab, PLLC**.

Signature (Patient/Guardian): _____

Date: _____

Release of Information (ROI)

I authorize **Cooper & Co. Language and Swallowing Lab, PLLC** to release/receive medical and educational information to/from the following:

Physician/School/Other Provider: _____

Fax/Phone/Email (if applicable): _____

This authorization is valid until revoked in writing.

Signature (Patient/Guardian): _____

Date: _____

Attendance & Cancellation Policy

We request a 24-hour notice for cancellations. Frequent no-shows or cancellations may result in discharge from therapy services. Late arrivals may result in shortened sessions.

I acknowledge and agree to follow the attendance and cancellation policy.

Signature (Patient/Guardian): _____

Date: _____

Media/Photo Consent

I give permission for photos/videos of my child/myself to be used for educational, training, or marketing purposes by **Cooper & Co. Language and Swallowing Lab, PLLC**. I understand that names and identifying details will remain confidential.

- Yes, I give consent
- No, I do not give consent

Signature (Patient/Guardian): _____

Date: _____