

About Us

Gallien Therapy Services was formed in June of 2005. It was a merger of Digame Speech and Language Consultants and RPM Physical Therapy. Digame was owned and operated by Pam Gallien. The company had been serving Otero County's speech language and swallowing needs for 20 years. RPM Physical Therapy was founded in March of 2004 by Ron Gallien and serviced Lincoln County.

It was felt by merging the two companies; Gallien Therapy could offer the people of the Tularosa Basin the best in rehabilitative services. Orthopedic physical therapy and a wide range of speech therapy services are available.

Our mission is to provide our patients with the best possible care to maximize their strengths, enable them to reach their fullest potential, and enhance quality of life. We work closely with your physician to ensure the best possible rehabilitation outcome.

The company takes most major insurances, including but not limited to: United Healthcare Military & Veterans (Tricare), Blue Cross Blue Shield, Presbyterian, Molina, Centennial Care, Medicare and Workers Compensation.

Physical Therapy Program

Gallien Therapy has only one focus: Orthopedic Physical Therapy. By specializing in just this one field of practice, we can provide our patients the most specialized care after an orthopedic injury or accident. We feel that having one focus leads to a better outcome for our patients.

Gallien Therapy understands the significance of each patient's surgery after an orthopedic injury. Every person is unique and their rehab must reflect that fact. Our therapists tailor an individualized treatment plan for each patient. We know that rehabilitation is a team effort with patient, physician and physical therapist working together to gain the best results.

Speech Therapy Program

Communication is the essence of life. Gallien Therapy understands the fact and offers the most advance treatment for speech, language and swallow disorders for patients of all ages. Whether it is loss of speech after a stroke or inability of a child to pronounce words appropriately, we have a program to help.

Imagine not being able to share a cup of coffee with a friend, or being a child and never enjoying a peanut butter and jelly sandwich. The inability to swallow is devastating. Gallien Therapy has the most comprehensive dysphagia program in Otero County. We offer Neuromuscular Electrical Stimulation which is the latest technology for treating patients with swallowing problems (dysphagia).

Our Staff:

Ron Gallien PT, OCS



Ron Gallien earned his Physical Therapy degree from the University of Texas Medical Branch in Galveston, TX, in August 1990. His work experience during the last 25 years has included outpatient rehab, acute care, and home health. He served as a Clinical Therapist for a large orthopedic physician group in Southeast Texas prior to moving to New Mexico. The focus of his past 20 years has been in treating orthopedic cases. He has been Board Certification from the American Board of Physical Therapy Specialties as an Orthopedic Specialist since May of 2002. At this time he is the only board certified specialist practicing in Alamogordo. During the course of his career, he has attended numerous continuing education classes focusing on orthopedics. He is proud to have been able to serve Otero and Lincoln Counties over the past 19 Years. He looks forward to continuing this service.

Pam Gallien MS, CCC/SLP



Pam Gallien graduated with a Master's degree in Speech-Language Pathology from Lamar University in Beaumont, TX, in August 1993. Her clinical fellowship year was spent at Southeast Texas Rehab Hospital. She received training in such areas as traumatic brain injury, dysphasia, and neurological disease. After moving to Alamogordo in 1994, she began a private practice serving patients of all ages. She became the owner of Digame Speech & Language Consultants in 1996. She has served the Tularosa Basin by offering a full range of diagnostic and treatment services designed to aid those with communication and swallow difficulties.

Chris Dirx, PT, DPT, Neuro-IFRAH



Chris graduated from Des Moines University in Iowa with his doctorate in physical therapy in 2012. Since graduating, he has practiced in a variety of settings, including nursing facilities, home health, working with student athletes, and spent two years at Gerald Champion Regional Medical Center. While at GCRMC, he worked as lead therapist for the Inpatient Rehabilitation Facility, as well as in the Joint Center program and acute care floors. Chris achieved Neuro IFRAH certification for the treatment of stroke and brain injuries in 2014. He is currently working on his MBA in Health Care Management from the University of Texas at Tyler, as well as beginning the process to become a Certified Orthopedic Manual Therapist.

GALLIEN
THERAPY SERVICES

Name: _____ Nickname (if any): _____

Parent or Guardian / Relationship (if minor): _____

Gender: Male Female Date of Birth: _____

Social Security Number: _____

Address: _____

Mailing Address (if different): _____

Phone Number: _____

Emergency Contact Name / Phone Number: _____

Email Address: _____

Would you like to receive appointment reminders? (Text / Voicemail / Email)

Yes No

Primary Insurance: _____

Secondary Insurance: _____

Additional Insurance Plans: _____

Policy Holder **if other than self** - Name: _____

Gender: Male Female Date of Birth: _____

Social Security Number: _____

Address: _____

Reason for referral (problem or injury): _____

Cause of injury or problem if known: _____

Referring Physician: _____

Are you currently receiving home health services? Yes No
List of Current Medications: Not currently taking any medications
(Please note a list of medications is a Medicare requirement)

Allergies (ex: latex, food, medications):

I give my consent for Gallien Therapy to provide medical care. I also give consent for Gallien Therapy to bill my insurance company for services provided.

Signature: _____ Date: _____

Authorization for Release of Information to Family Members

Patient Name: _____

Date of Birth: _____

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Gallien Therapy Services to release my medical and / or billing information to the following individual(s):

1. _____ Relation to Patient _____

2. _____ Relation to Patient _____

3. _____ Relation to Patient _____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any one listed above is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.

Signature _____ Date: _____

Name: _____

Date: _____

<input type="checkbox"/> Chronic Colds/Respiratory infections	<input type="checkbox"/> Temporary Hearing Loss	<input type="checkbox"/> Previously diagnosed global developmental delay
<input type="checkbox"/> Chronic Ear infections	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Asthma
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Eye Problems	<input type="checkbox"/> Allergies
<input type="checkbox"/> Head Trauma	<input type="checkbox"/> Attention Deficit Disorder (ADD/ADHD)	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> High Fever		

Please list any other serious illness or condition: _____

Please list and explain any hospitalizations for illness or operation: _____

Please list any allergies your child has: _____

Is there any known history of the following in the immediate or extended family?

<input type="checkbox"/> Autism/PDD	<input type="checkbox"/> ADHD	<input type="checkbox"/> Learning Disabilities
<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Stuttering	<input type="checkbox"/> Speech/Language Delays

Has your child received speech therapy before? Yes No

If yes, at what age and where? _____

PREGNANCY & BIRTH HISTORY

Did mother have any illnesses or complications during pregnancy or delivery? Yes No

Comments: _____

Any medications, alcohol or other drug use during pregnancy? Yes No

Comments: _____

At how many weeks was the child born _____ Birth Weight _____

Did child require hospital stay or time in NICU? Yes No

Comments: _____

CONCERNS

At what age did you first become concerned about your child's speech? _____

What caused your concern? _____

SPEECH & LANGUAGE DEVELOPMENT

Please describe your child’s primary mode of communication (gestures, signing, single words, short phrases, sentences, augmentative device, picture exchange)? _____

If your child is talking, please indicate at what age your child began to:
 Babble _____ 2-3 word phrases _____ First words _____
 Use language as primary mode of communication _____

How much of your child’s speech do you understand? (Please circle one)
 25% or less 24-50% 50-75% 75-100%

How much of your child’s speech do others understand? (Please circle one)
 25% or less 24-50% 50-75% 75-100%

Are there any specific sounds your child has difficulty saying? _____

Does your child demonstrate frustration when he/she is not understood? Yes No
 If yes, please explain: _____

BEHAVIOR & SOCIAL SKILLS

Follows verbal directions	Yes	No	Comment:
Initiates conversations	Yes	No	Comment:
Makes eye contact when speaking	Yes	No	Comment:
Has safety awareness	Yes	No	Comment:
Is impulsive or a risk taker	Yes	No	Comment:
Displays aggression toward self or others	Yes	No	Comment:
Enjoys rough house play	Yes	No	Comment:

Please provide any further information you feel would be helpful regarding your child.

 Child’s Name Parent/Guardian Signature Date

Gallien Therapy

Cancellation Policy

Gallien Therapy holds the belief that the success you achieve in therapy begins with the consistency of treatment. Therefore, we are committed to doing our best to be here to treat you every day. We also believe that mutual trust is the key to good relationships and we trust that you will place the utmost importance on maintaining your appointments as well.

Understanding the importance of consistent attendance, Gallien Therapy requires a 24 hour notice for the cancellation or re-scheduling of a scheduled appointment. There is a \$25 charge for a no-show or cancellation without proper notice. This charge WILL NOT be covered by your insurance and will be billed directly to you, the patient. This fee must be paid prior to being seen for your next scheduled appointment.

We understand that extenuating circumstances may occur and require cancellation within the 24 hour period. Reasons for absence should be limited to patient or child illness or other family emergency situations. In these emergency situations, the \$25 fee may be waived. The determination of an emergency shall be at the sole discretion of Gallien Therapy.

If you should happen to no-show without notice 3 times, or are absent for more than 20% of your scheduled appointments over the course of treatment, your therapist may discharge you from therapy and no further visits will be scheduled.

Lateness Policy

It is equally important that you be on time for your scheduled appointment. You are welcome to call in advance to request an earlier or later time. We will be happy to honor your request if other appointment times are available. If you arrive late, your session may be shortened as to not adversely affect the treatment time of the appointment that follows yours. If you are more than 10 minutes late for your scheduled appointment, your therapist may determine insufficient time is available to adequately treat you that day, and your appointment may be cancelled.

We take these policies seriously because three people are adversely affected when you miss a treatment:

1. You the patient- for not receiving the treatment you need
2. Your therapist- as now he or she has a gap in their schedule
3. Another patient- who could have had your appointment time to get treatment

We appreciate your understanding in this matter.

I have read and fully understand these policies

Print name of patient/ Guardian

Date of Birth

Signature of patient/ Guardian

Date