Documentation Check List

(For Office Use only)

Please include the following documents (if available):

Provided by Speak Advantage (via website/office):

- ❒ Client Intake Form
- ❒ Case History Form
- ❒ Release Forms
- ❒ Policies and Procedure Form
- ❒ Notice of Privacy Practices/Form

Provided by Parent/Guardian:

- ❒ **Copy of front and back of medical insurance card**
- ❒ Most recent hearing screening
- ❒ Copy of IEP/IFSP (if applicable)
- ❒ Copy of most recent therapy comprehensive evaluation(s) (if applicable)

CLIENT INTAKE FORM

(Please Print)

Today's date:	**Parents Name:**

PATIENT INFORMATION

Patient's last name:	First:	Middle:

Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Cellphone:	Home phone no.: ()

P.O. box:	City:	State:	ZIP Code:

Daycare/School:	Teacher Name:	phone no.: ( )

Physician:	Address:	Phone:	Fax:

INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ()

Please indicate primary insurance	❑BCBS	❑United Health	❑Medicaid	❑Cigna ❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	**Policy no.:**	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			

PLEASE ATTACHED A COPY OF THE INSURANCE CARD

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Speak Advantageor insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Speech and Language Therapy Case History

The following information is for professional use and will be handled confidentially. This information will assist the speech language pathologist in completing your child's evaluation.

Please complete the following questions as fully and accurately as possible. If you are unable to complete a question, please leave it blank or you may call our office for assistance at (919)537-9425

General Information

Child's Name: _____ Age: _____

Child lives with (check one):

☐Birth Mom/Dad ☐Birth Mom/Dad and Stepparent ☐ Grandparents
☐ Adoptive Parents / Foster Parents ☐ Boyfriend/Girlfriend _____

Other children in the family:

Name	Age	Sex	Grade	Speech/Hearing Problems

Speech-Language and Hearing Information

Has he/she ever had a speech evaluation/screening and/or therapy? ☐ Yes ☐ No
If yes, where and when?_____
What were you told?_____
What was he/she working on? _____
_____

Do you feel your child has a hearing problem? ☐ Yes ☐ No
If yes, please describe._____
_____
_____

Has he/she ever had a hearing evaluation/screening? ☐ Yes ☐ No
If yes, where and when?_____
What were you told?_____

Occurrence of ear infections ☐ Yes ☐ No _____
If "yes", approximately how many ear infections to date:_____

Last date of ear infection _____
Please explain course of treatment: _____
_____

Has your child received any other evaluation or therapy (physical therapy, counseling, occupational therapy, vision, etc.)? ☐ Yes ☐ No
If yes, please describe:_____
_____
_____

Is your child aware of, or frustrated by, any speech/language difficulties?_____
_____
_____

Please indicate your primary concern about your child's speech and language skills: _____
_____
_____

Birth History

Was there anything unusual about the pregnancy or birth? □ **Yes** □ **No**
If yes, please describe._____
_____
_____

Was the mother sick during the pregnancy? □ **Yes** □ **No**
If yes, please describe. _____
_____
_____

How many months was the pregnancy?_____

Did the child go home with his/her mother from the hospital? □ **Yes** □ **No**
If child stayed at the hospital, please describe why and how long._____
_____
_____

Medical History

Has your child had any of the following?

□ Adenoidectomy	□ Ear tubes	□ Head injury	□ Sinusitis
□ Breathing difficulties	□ Encephalitis	□ High fevers	□ Sleeping difficulties
□ Chicken pox	□ Flu	□ Measles	□ Thumb/finger sucking habit
□ Meningitis	□ Tonsillectomy	□ Mumps	□ Tonsillitis
□ Seizures	□ Vision problems		

□ Ear infections If yes, when and how many:_____
□ Allergies If yes, Please list: _____
_____

Other serious injury/surgery:_____
_____

Is your child currently (or recently) under a physician's care? □ **Yes** □ **No**
If yes, why? _____
_____

Please list any medications your child takes regularly:_____
_____
_____

Has your child ever been hospitalized? □ **Yes** □ **No** If yes, why?_____
_____
_____

Developmental History

Were the following developmental milestones achieved within the appropriate age range?□ **Yes** □ **No**
If not, specify age next to milestone:

_____ Sat alone	_____ Grasped crayon/pencil
_____ Babbled	_____ Said first words
_____ Put two words together	_____ Spoke in short sentences
_____ Walked	_____ Toilet trained

Education Information

Is your child currently enrolled in school? □ **Yes** □ **No** If yes, school name and grade: _____

_____

_____

Supportive Services

What other services is your child currently receiving both in-school and out of school? Please enclose a copy of the child's most recent IEP or IFSP and Therapy goals from each area that is checked.

Service/Therapy	Location	Minutes/Week
☐ Early Intervention Services	☐ School ☐ Home	
☐ Speech and/or language therapy	☐ School ☐ Home	
☐ Occupational and/or Physical Therapy	☐ School ☐ Home	
☐ Vision services in school	☐ School ☐ Home	
☐ Hearing services	☐ School ☐ Home	

Consent for Treatment and Evaluate

I give consent for Speak Advantage, PLLC to treat and evaluate my child for therapy services. I understand that my child will be re-evaluated after 6 months of the initial evaluation to update plan of care and to provide effective treatment services.

_____ _____

Parent/Guardian Signature Date

Consent to Release Information

I authorize the release of information to Speak Advantage, PLLC. I also authorize Speak Advantage, PLLC to release information to my referring physician, insurance company or Medicaid program for the purposes of continued care to treatment and to any other person financially responsible to my child's treatment for all purposes related to a claim for payment and/or approval for services

_____ _____

Parent/Guardian Signature Date

Authorization of Insurance/Financial Agreement

I request that payment of authorized benefits be made to Speak Advantage, PLLC. I understand that I am responsible for any amount applied to the deductible, including the percentage of co-insurance/co-payment and any non-covered services under the insurance program. Payment is to be provided in full at the time of service or in advance of your visit.

It is your responsibility to inform us of any changes in your address, phone numbers, employment and medical benefits. Services which are denied by insurance as a result of appropriate information not being supplied will become the responsibility of the patient. In order for us to honor your insurance; we must be able to verify your coverage and current benefits. If verification cannot be made you will be responsible for the full charges to be paid at the time of service.

_____ _____

Parent/Guardian Signature Date

Video/Photograph Release

I hereby authorize Speak Advantage, PLLC to photograph, audio tape, and/or video tape my child.

_____ _____

Parent/Guardian Signature Date

I hereby authorize Speak Advantage, PLLC to use photographs, audio tapes, and/or video tapes of my child for educational, advertising purposes, reports for insurance companies, referring physicians and other families for continued care.

_____ _____

Parent/Guardian Signature Date

Attendance Policy

We at Speak Advantage appreciate your services and would like to make sure your child receives the most effective therapy by providing standard appointments. Regular attendance will provide your child with the best outcome. Please follow the attendance policy outlined below:

1. **Cancellations**: Please CALL at least 24 hours before scheduled appointment. We reserve the rights to charge a $25.00 fee if proper notice is not performed. This fee is due at the next scheduled visit. Therapy services will not continue until this fee is paid. Insurance companies will not cover this fee.

2. **Attendance:** Clients who attend less than 50% of scheduled treatment visits, will have services put on HOLD until scheduling problems can be resolved.

3. **Late Appointments:** Please call if you're going to be more than 5 minutes late for scheduled appointment. Three (3) consecutive late visits will result in placing services on hold until issue is resolved.

By signing below, I verify that I have read and understand the above statements and agree to follow Speak Advantage, PLLC attendance policy.

_____ _____

Parent/Guardian Signature Date

Notice of Privacy Practices

I, _____, have been made aware in writing of my right to confidentiality regarding the privacy practices with Speak Advantage, PLLC. We are required by law to provide you with a copy of our privacy notice.

_____ _____

Parent/Guardian Signature Date

HIPAA NOTICE OF PRIVACY PRACTICES
Speak Advantage, PLLC

Notice of Privacy Practices:
This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully.

It is Speak Advantage policy to keep your health information safe. Your health information is contained in a Speak Advantage, PLLC.

Disclosure of your health care information:
Treatment: Your health information may be used to provide you with medical treatment or services. This information is necessary for health care providers to determine what treatment you should receive. Healthcare providers will also record actions taken by them in the course of your treatment and note how you respond to the actions. If you are enrolled in the Children's Development Service Agency (CDSA) this information will be shared with the local CDSA office.

Payment: Speak Advantage may use and disclose your health information to others for the purpose of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third party payer, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment.

Public Health: As required by law, Speak Advantage may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, reporting child abuse or neglect, reporting domestic violence, and reporting disease or infection exposure.

Public Safety: It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health and safety of a particular person or to the general public.

Specialized Government Agencies: Speak Advantage may disclose your health information for government benefit purposes.

Healthcare Operations: Speak Advantage may use or disclose, as needed, your protected health information in order to support the business activities of my practice. For example, Speak Advantage may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. Except as required by law, any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and Speak Advantage is required to honor and abide by that written request, except to the extent that I have already taken actions relying on your authorization.

Your Health Information Rights:
You have the right to request restrictions on certain uses and disclosures or your health information. Please be advised, however, that your health provider is not required to agree to the restriction that you requested.

You have the right to have your health information received or communicated through alternative methods or sent to an alternative location other than the usual method of communication or delivery, upon your request. You have the right to inspect and copy your health information.

You have the right to request that your health record be amended.

You have the right to receive an accounting of disclosures of your protected health information made by me.
You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to This Notice of Privacy Practices: Speak Advantage reserve the right to change this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such change is made, Speak Advantage is required by law to comply with this Notice.

Obligation of Speak Advantage, PLLC: Speak Advantage is required by law to maintain the privacy of your health information and to provide you with notice of my legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about your privacy rights, please contact Ebony Williams, owner and privacy officer. You may review HIPAA guidelines at http://www.hhs.gov/ocr/privacy/

Complaints:
Any complaints about your privacy rights, or how Speak Advantage handled your health information should be directed to Ebony Williams, owner and privacy officer, by calling (919)537-9425.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
Speak Advantage will not retaliate against you for filing a complaint.
This notice was published and becomes effective on January 10, 2012.