Comprehensive Speech and Therapy Center, Inc.

Client Information (Child)

Client Full Name:____ Date:_____________

Date of Birth: ___/___/___ Age: ______ Sex: _____ Social Security #: ____________________

Telephone: Home #: (____)______________________ Cell #: ____________________________

Home Address: ____

City/State/Zip: ____

Mother's Name:_________________________Age: _______Occupation: ____________________

Father's Name:__________________________Age: _______Occupation: ____________________

Siblings/Ages: ____

Primary Care Physician: _______________________Phone #: (___)________________________

Others Living in the Home: ____

Languages Spoke in the Home: ____

Who is responsible for this client's bills: ____

Address: _______________________ City: __________ State: ________ Zip Code: ____________

Phone #: _______________________ Social Security #: ______________ Date of Birth: __________

Employer: ____ Phone #: _______________________

Address of Employer: ____

Would you like assistance in obtaining insurance reimbursement: ☐Yes ☐No

Whom may we contact in the event of an emergency (other than parent)?

Name: ____ Telephone #: (____)___________________

Relationship: ____

Who may we thank for referring you**:** ____

BIRTH HISTORY

Pregnancy:

Age of mother: ____________________Length of pregnancy:__________________________________

General Health of Mother:____

Complications: ____

Medications taken during pregnancy:____

Delivery:

Duration of Labor:__________________________ Type of Delivery:____________________________

Difficulties during delivery: ____

____

Birth Weight: ______________ Birth Length:__________________ Apgar score:__________________

Intensive care (NICU) needed? ☐Yes ☐No Length of stay:________________________________

Any health problems the first 2 weeks of life?____

____

MEDICAL HISTORY

Hospitalizations:	☐ Yes	☐ No	Describe:____________________________________
High Fevers:	☐ Yes	☐ No	Describe:____________________________________
Ear Infections:	☐ Yes	☐ No	Describe:____________________________________
Hearing Problems:	☐ Yes	☐ No	Describe:____________________________________
Vision Problems:	☐ Yes	☐ No	Describe:____________________________________
Allergies:	☐ Yes	☐ No	Describe:____________________________________
Surgeries:	☐ Yes	☐ No	Describe:____________________________________
Seizure Disorder:	☐ Yes	☐ No	Describe:____________________________________
Colic	☐ Yes	☐ No	Describe:____________________________________
Constipation/Diarrhea	☐ Yes	☐ No	Describe:____________________________________

Is your child presently under the care of any doctor other than your pediatrician? □Yes □No

Name of Doctor: ______________________________ Reason: _______________________________

____

Medications (Current/Previous): ____

MEDICAL PRECAUTIONS: Are there any precautions the therapist should be aware of when working with your child? ____

____

Developmental History

Motor milestones: At what age did your child:

Roll:______ Sit:______ Pull to stand:______Crawl:______ Walk: ______ Ride a tricycle: ______

Ride a bike: ______ Use a writing utensil: ______ Cut with scissors: ______Feed self: ______

Reach for objects: ______ Drink from a cup: ______ Use a straw: ______ Toilet training: ______

Speech/Language milestones: At what age did your child:

Babble: ______ First word: ______ Combine two words: _______ Use sentences: ______

Does your child speak clearly? □ Yes □ No Do others understand your child? □ Yes □ No

Is your child's voice hoarse or husky? □ Yes □ No Describe_______________________________

Does your child stutter? □ Yes □ No Describe____

Is your child self conscious about his/her speech? □ Yes □ No Describe_____________________

Self Care Skills:

Please describe your child's current level of function with the following activities:

Dressing: ____

Toileting: ____

Bathing: ____

Hygiene: ____

Sleeping: ____

Feeding: ____

Social History:

How does your child play with other children (cooperative, leader, lone, aggressive, picked on, ect):

____

Does your child make friends easily? ☐ Yes ☐ No
Does your child need to be in control? ☐ Yes ☐ No

List any concerns you may have about your child's social skills:

____

Favorite Toys/Activities:____

Behavior:

______No Specific Problems ______Short Attention Span _____Self Injurious Behavior

______Easily Frustrated ______Plays Well With Others _____Redirects with the following Supports: _____________

______ Difficult to Discipline ______Easily Distracted ____________________________

EDUCATIONAL HISTORY:

Schools attended (please include day care and preschools): Current grade: _________

Dates Attended:	Name/Location/District

Is your child in a special education classroom and/or receiving special education services?
☐ Yes ☐ No Primary special education eligibility: ________________________

Describe services: ____

____

THERAPY HISTORY:

List any therapy your child has received (when, where, and duration treatment):

____

Is there any other important information that you feel may be helpful to your child's treatment?

____

What goals would you like your child to achieve through therapy?

____

This information will be kept confidential and used solely for the purpose of providing the appropriate care to the client. Thank you.

Comprehensive Speech and Therapy Center, Inc.
1001 Laurence Ave. ♦ Suite B
Jackson, MI 49202
Phone: (517) 750-4777

CONSENT FOR SERVICES & PAYMENT POLICY GUIDELINES

I/ We, ______________________________ give permission to Comprehensive Speech and Therapy Center (CSTC), Inc. to render services to ____________________ .

I/We agree to the following:

CANCELLATION POLICY: Appointment cancellation requires **a prompt** notification. If an appointment is missed without appropriate notification a $25.00 "no show" fee with be assessed.

AUTHORIZATION: I/We grant permission to CSTC to interview, videotape, photograph, or record the patient for clinical, educational, professional purposes, or other as is common practice in this field.

RELEASE: I/We request rehabilitation services from CSTC and consent to the treatment ordered by my physician who monitors, approves and certifies the need for my care. I consent to the release of information and a copy of my medical records to CSTC by any health care provider where I received treatment.

SERVICES AND PAYMENT: Following the initial evaluation, CSTC will recommend the necessary frequency and duration of treatment. A written report will be provided by CSTC inclusive of a treatment plan and goals. CSTC will provide verbal and/or written update of progress and goals at no additional charge every 90 days. All fees are to be paid at the time of each visit unless prior payment arrangements have been made. Accounts which become 30 days overdue will be assessed a 1.5% fee on the outstanding balance each month.

Insurance/Secondary Payer

- As a courtesy to you and your family, we will bill your insurance company for the services rendered at our facility, if appropriate.

- To the extent necessary to determine liability for payment and to obtain reimbursement, COMPREHENSIVE SPEECH AND THERAPY CENTER, INC. may disclose portions of the patient's record including his/her clinical records to any person or corporation which is or may be liable for all or any portion of COMPREHENSIVE SPEECH AND THERAPY CENTER, INC. charges, including but not limited to insurance companies or health care service plans.

- **You are responsible for any co-pay or deductible you have at the time of service.**

- The undersigned agrees, whether he/she signs as the agent or the patient, that in consideration of the services to be provided, he/she hereby individually obligates himself/herself to pay the account of COMPREHENSIVE SPEECH AND THERAPY CENTER, INC. in accordance with its regular charges and/or as set forth by the terms of a managed care contract entered into by COMPREHENSIVE SPEECH AND THERAPY CENTER, INC.

- The undersigned authorizes whether he/she signs as agent or patient, direct payment to COMPREHENSIVE SPEECH AND THERAPY CENTER, INC. of any insurance benefits otherwise payable to the undersigned. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

- Should your insurance company fail to compensate COMPREHENSIVE SPEECH AND THERAPY CENTER, INC. within 60 days for services and/or reimbursements at a lower rate than ours, **you will be responsible, in full, for all fees and services which have been rendered.**

- The undersigned, if a Medicare patient, certifies, whether he/she signs as agent or the patient, that the information given in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

- Should the account be referred to an attorney for collection, the undersigned shall pay actual attorney's fees and collection expense. All delinquent accounts shall bear interest at the legal rate.

The undersigned certifies that he/she has read the foregoing and is the patient or is duly authorized by the patient to execute the above and accept its terms.

Patient's Name (print)________________________________Clinical Record#___________

Signature____Date____________

Witness____Date____________

If the patient did not sign this form, what is the relationship of the signer to the patient?

____

Reason for not signing____

PATIENT CONSENT AND PAYMENT AUTHORIZATION

Comprehensive Speech and Therapy Center, Inc.
1001 Laurence Ave. ♦ Suite B
Jackson, MI 49202
Phone: (517) 750-4777

RELEASE OF INFORMATION

I/We, ______________________________, authorize Comprehensive Speech and Therapy Center, Inc. to release information **to** physician and/or facility as listed below.

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Regarding: ☐ myself ☐ my son/daughter ☐ my parent/spouse

____
Signature of patient, spouse, parent, legal guardian Date

______________________________ ______________________________
Social Security # DOB

Records may be secured **from**:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

____
Signature of patient, spouse, parent, legal guardian Date

COMPREHENSIVE SPEECH AND THERAPY CENTER, INC.
1001 Laurence Ave., Suite B
Jackson MI 49202
517-750-4777

Notice of Privacy Practices (HIPPA)

This notice describes how medical information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

This notice is being provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPPA). This notice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, and healthcare operations and for other purposes that are permitted or required by law. PHI includes any of your written or oral health information including demographic data that can be used to identify you. This is PHI that is created or received by Comprehensive Speech and Language Center, Inc. (CSLC) and/or its agent.

Understanding Your Health Information

Each time you receive health related services a record is made of the treatment. Typically, this record contains your diagnosis and treatment notes. This information, often referred to as a health, treatment or medical record, serves as a:

- Basis for planning your care
- Means of communicating among the health professionals, e.g. therapists or physician who contribute to your care
- Legal document describing the care you received and
- Means by which you or a third-party payer can verify that services billed were actually provided

Your Health Information Rights

Although your health record is the physical property of CSLC, the information belongs to you. You have the right to:

- Request a restricition on certain uses and disclosure of your information as provided by 45 CFR 164.522
- Receive confidential communications of protected health information as provided by 45 CRF 164.522
- Inspect and copy your health record as provided for in 45 CFR 164.522
- Request to amend your health record as provided in 45 CRF 164.522
- Obtain an accounting of disclosure of your health information as provided in 45 CFR 164.522
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken
- Obtain a paper copy of the notice from CSLC upon request

The right to make a request does not guarantee it will be granted, the request may be denied based on certain situations; including, emergency treatment, disclosures to the Secretary of the Department of Health and Human Services, for example. All requests must be made in writing.

Comprehensive Speech and Language Center, Inc. Responsibilities

- Maintain the privacy of your protected health information (PHI)
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction

We will not use or disclose your health information without your authorization, except as described in this notice:

We will use your health information for treatment.

For example, information obtained by a health related services provider, e.g. primary care physician, physical therapist, audiologist, occupational therapist, speech/language pathologist, and/or psychologist, will be recorded in your record and used to determine the best plan of care for you.

We will use your Protected Health Information for payment. We may use and give your health information to electronically bill third party payers and collect payment for treatment services provided to you by a contracted agent or us.

By Signing below I acknowledge that I have reviewed the HIPPA Guidelines.

____ _____________________________

Signature **Date**