CLIENT INFORMATION

Patient: _____ DOB: _____Sponsor's SSN: _____
Last First Middle

Address: _____
Street City ZIP

Is this patient a foster child? Yes___No____

Case Worker Name: _____ Phone: _____ County: _____
Last First

Parent/Guardian Information (if applicable)

Name: _____ DOB: _____
Last First Middle

Address: _____
Street City ZIP

Cell Phone: _____ Text: Y or N Email:_____

Name: _____ DOB: _____
Last First Middle

Address:_____
Street City ZIP

Cell Phone: _____ Text: Y or N Email: _____

Physician

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Patient Name: _____ Date of Birth: _____

Insurance

Primary Insured: _____ DOB: _____

Primary Insurance Carrier: _____ Phone Number: _____

Billing Claim Address: _____ City: _____ State: _____

ID #: _____Group #: _____

Secondary Insurance: _____

Policyholder Name: _____ DOB: _____

Phone Number: _____ Billing/Claim Address: _____

City: _____ State: _____ ZIP: _____

Policy Group #: _____ Group #: _____

Assignment of Benefits (insurance patients only):

I _____ , authorize the release of any payment and medical information necessary to process me or my family member's insurance claim and related claims. I hereby authorize payment directly to The Speech House of the insurance benefits otherwise payable to me for all professional services.

Signature of Responsible Party: _____Date: _____

Payment Contract

Under your health plan, you are financially responsible for co-payments, co-insurance or deductibles for covered services. You acknowledge that you have been told in advance by your provider that the services/products listed: Speech or Occupation therapy, may or may not be covered by your Health Plan. You agree to pay for any non-covered services.

Responsible Party: _____

Relationship Party: Self_____ Parent_____ Other(specify)_____

Signature: _____

POLICIES AND PROCEDURES

FLEX SCHEDULE

TSH is committed to providing all our clients with exceptional and consistent care. We believe that your commitment to your child's therapy schedule is essential to their progress and ultimate development. We thank you in advance for your cooperation and attention to our attendance policy. Helping your child to reach their maximum potential and making everyday differences in their lives is our privilege! Cancellations, late cancellations, and no shows compromise your child's progress and prevent another child from receiving services that day. **Please call/text the office at 573-336-1970 by 3:00 p.m. on the day before your scheduled appointment to notify us of any changes or cancellations.**

Flex Schedule allows more flexibility for our families whose schedules change week to week or due to medical appointments or other circumstances, regular appointment times/days are challenging. When om the Flex Schedule, there is no guarantee of availability of one particular therapist, specific time, or day. Please let us know if the flex schedule works better for your family. We re-evaluate monthly for continuing/discontinuing flex schedule within staff/with family.

Your child will be changed to a flex schedule for the following reasons:
Late Cancellations: More than 3 appointments per 3 months cancelled after 3:00 p.m. the day prior to your child's appointment.
Chronic Cancellations: Attendance at less than 80% of scheduled appointments.
Additional Attendance Policies:
Vacation: Appointment time not held for more than 2 weeks.
Unexcused Absences of 2 weeks or greater: a new order may be needed and the appointment time is no longer held.

HEALTH POLICY

Help and cooperation is required to maintain a healthy environment. A child must be temperature-free for 24 hours before returning to therapy. If your child has experienced vomiting and/or diarrhea, he/she should not return to therapy until 24 hours have passed since the last episode of the same.
Please do not bring sick or febrile family members to the clinic.
Children will not be seen if any of the following is present: Too ill or uncomfortable to function in the therapy setting, continual runny nose; thick or discolored nasal discharge; excessive sneezing or coughing and mucus-producing cough; an elevated temperature.

Strict CDC guidelines are followed for COVID-19.

SIBLINGS

If you need to bring siblings to the clinic, please have them use their inside voices in the waiting room and be respectful of our space, so as not to disturb others in session or waiting in the shared space.

TELETHERAPY

Teletherapy services are offered for both children and adults. It is used as a primary service mode as well as a substitute when clinic visits are not possible due to various factors, including but not limited to inclement weather, unexpected change to your work schedule, transportation difficulty and illness (quarantine).

HEALTH INSURANCE

We participate with some insurance companies, but not all. If The Speech House is not contracted with your insurance, we will be happy to provide you with a superbill to assist you in seeking reimbursement for out-of-network provider services. Please also be advised that many health insurance plans have limited coverage for therapy services. We recommend that you contact your insurance company to discuss the limits of your coverage.

FEES

The person who completes the **Party Responsible for Payment** section is responsible for payment of all services rendered. Payment is due at the time services are rendered unless you have made other arrangements in advance. **Accounts more than 30 days overdue will be subject to a $20.00 late fee and 5% interest charge. Accounts more than 90 days overdue will be sent to collections**. For clients seeking insurance reimbursement, please be aware that **you are ultimately responsible for the payment of services rendered. If your insurance carrier denies payment (including recoupment) the client will be responsible for payment of all services rendered.**

CONSENT/PAYMENT FORM

This form must be completed before services can be initiated. If the client is under the age of 18 years, the form must be signed by the legal guardian.

CONSENT FOR TREATMENT

I hereby attest that I have voluntarily applied for and entered into treatment or give my consent for the minor or person under my legal guardianship, at The Speech House. I understand that I may terminate these services at any time.

TERMINATION OF SERVICES

Due to the importance of continuity of care, regular attendance to appointments is necessary. If excessive appointments are missed and/or canceled, The Speech House reserves the right to discharge services. If you do not keep your financial obligations to The Speech House and remain delinquent on your account for more than 30 days (about 4 and a half weeks), services will be suspended until payment is received. Services may also be terminated if it is determined that continued participation will be a detriment to the child or their family. The Speech Language Pathologist reserves the right and professional judgement to discontinue services.

Signature: _____-

Notice of Privacy Practices and Confidentiality Agreement

-This Notice describes how health information about your child may be used and disclosed and how you can get access to this information.

The federal government has legislated the Health Information Portability and Accountability Act (HIPAA). The new rules regulate the privacy and accessibility of health information regarding your child's care at The Speech House. We must follow these privacy practices that are described in this notice until they are changed. You may request a copy of your notice at any time applicable by law. Any changes that will be added to this form will be available to you. You may request a copy of this at any time.

Use and Disclosure Information

Treatment - We may use or disclose your child's health information to plan a course of treatment that includes evaluation, goals and treatment approach. At times, your child's medical information may be reviewed by a student intern at our facility. In addition, your child's medical records will be provided to your health plan and consulting physicians. Your child may receive therapy services in the same room as another child. Within the Speech House, your child's goals and data pertinent to your child's treatment may be discussed with others.

Payment - We may use and disclose your health information to obtain payment for services we provide to you/your family member. A bill may be sent to you or your health insurance payer. The information on the bill may obtain information that identifies you, your spouse or your child. This information may include the child's date of birth, diagnosis and procedures or supplies used.

Appointments -We may use or disclose your health information to provide you with appointment reminders (such as email, voicemail messages, postcards or letters).

Check-In - Your child's name may be called when checking in at our desk.

Schools and Agencies - We may provide information requested for IEP's, MFE's and evaluations with other professionals. We may disclose your child's information to doctors and other health professionals in regard to your child's care with us.

Other Permitted Uses and Disclosures - We may share information with other public health authorities charged with preventing or controlling disease, injury or disability. We will notify appropriate persons if we suspect child abuse or neglect. We may need to provide medical information regarding your child to legal/judicial/administrative and law enforcement person. We may need to send you information regarding your child's care or billing issues through the mail. We may also send you information about groups and programs. This information may come in a marked envelope with our address on it. We will not use or disclose your child's health information without your written authorization.

Confidentiality- No information regarding other patients may be shared outside the walls of The Speech House without parental permission.

Patient's Rights

- You have the right to view your child's health record and request a copy of it. There may be a copying and postage fee. You may be asked to show proof of guardianship or parental (driver's license, court order).
- You may request an amendment to your child's record. We are not required to make this change, but it will be noted in the record.
- You may restrict anything in our privacy act. We are not required to honor your request but will make all efforts to accommodate reasonable request. You may fax or mail this to us.
- Provide written authorization for uses and disclosures not otherwise permitted by law.

Signature: _____

HIPAA Release of Information Authorization Form

I hereby authorize The Speech House and its affiliates, its employees and agents , the ability to send me electronic communication containing my personal health information maintained (such as information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, Member ID number, payment arrangements and balance information) except the following information about me:

_____

___(DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY] for the purpose of helping me to resolve claims, or health benefit coverage issues, and the purpose of communication regarding plan of care. I also allow the Speech House staff members involved in the care of my child to email internally to each other and externally to other professionals involved in the care of the child. I understand that the electronic communication will be sent via an unsecure/unencrypted email network. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. I understand that I have a right to revoke this authorization by providing written notice to The Speech House. However, this authorization may not be revoked if The Speech House, its employees or agents have acted on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign may affect my eligibility for benefits or enrollment or payment for coverage of services.

Signature: _____

Release of Information Form

Child's Name: _____ Date of Birth: _____

This form allows The Speech House to send and receive EVALS, reports, and other requested information, including sending claims to your insurance provider. If we do not have this form filled out, we will not be able to provide this service on your patient's behalf.

I hereby authorize any physician, clinic, hospital, institution or school to release Medical and Psychological information regarding my child to The Speech House. I understand that this information is to be used for professional purposes only and that it will be regarded as confidential. I also authorize The Speech House to contact any persons or institutions to obtain any additional information regarding my child, when necessary.

I hereby authorize The Speech House to release therapy reports regarding my child to any entity or professional associated with my child's care (physicians, any clinic, hospital, institution, insurance company, school, and other), with the exception of:
_____. This authorization includes release of information concerning HIV testing or treatment of AIDS, AIDS-related conditions, drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions.

I give my permission for The Speech House to photograph and/or videotape my child, and use *said* photos/videos for promotional or teaching purposes.

☐ Yes
☐ No

Signature: _____

Individualized Needs Assessment

Child's Name: _____ DOB: _____

Name of Person Completing Form: _____ Relationship to Child: _____

Is your child adopted: _____ Child lives with both parents? Yes___ No_____ If no, who does the child live with? _____ Primary Language: _____ Secondary Language: _____

Previous speech therapy evaluations (list): _____

Other therapies to date (list): _____

Describe present problem/chief complaint: _____

_____

_____

_____

Who noted the present problem? _____ When did it start? _____

What is your child's reaction to the problem? _____

_____

How does the family react/ Is He/She aware? _____

_____

Has there been any significant change in the last six months regarding the chief complaint/problem or overall? _____If so, what? _____

_____

How well is your child understood? (i.e., what percentage of the time?)

Parents: _____ Younger siblings: _____ Older siblings: _____ Grandparents: _____

Other children: _____ Extended family: _____ Unfamiliar adults: _____

Provide an example of a conversation with your child: _____

_____

_____

PRENATAL/BIRTH HISTORY

Full Term: Yes_____ No _____ If no, how many weeks? _____

Birth Hospital: _____ State: _____

Illnesses or accidents during pregnancy: _____

Use of alcohol, tobacco, or medications during pregnancy: Y/N

Birth weight: _____ Delivery: Vaginal____ Cesarean_____ N.I.C.U. Y/N

Breech (Feet First): ____ Head First: ____ Respiratory Issues at birth: _____

Other unusual conditions that may have affected pregnancy or birth? _____

_____

Medical History

Please check if your child has had any of the following:

☐ Seizures ☐ High fevers ☐ Chicken pox ☐ Whooping cough/Diphtheria ☐ Croup ☐ Pneumonia ☐ Tonsillitis ☐ Meningitis ☐ Encephalitis ☐ Rheumatic fever ☐ Tuberculosis ☐ Sinusitis ☐ Chronic colds ☐ Enlarged glands ☐ Thyroid ☐ Asthma ☐ Heart trouble Other: _____

Explain any checked items here: _____

_____

Diagnosis: _____

Are immunizations current? N Flu: N COVID: N (Circle)

Have you traveled outside the U.S. within the past 60 days? N

If so, where? _____

Current General Health

Current diagnosis: _____

Hospitalizations: □ No □ Yes; If yes, please describe: _____

Surgeries: □No □ Yes; If yes, please list: _____

_____

Previous psychological evaluation? □No □Yes; If yes, please describe: _____

_____

Medications: _____

Special Equipment: Splints: ____ Braces: ____ Adaptive Utensils: ____ Other: _____

Any feeding problems or nutritional concerns? _____

Please check all that apply to your child:

☐ Trach D ☐ Allergies (list below) ☐ C-Line ☐ Latex sensitivity ☐ G-tube ☐ Hearing aids ☐ Hearing difficulty ☐ Wears glasses ☐ Vision problem

Educational information

School/Educational program currently attending: _____

Present grade level: _____

Special services received in school: ☐ OT ☐ PT ☐ Speech

Does your child receive any of the following?

☐ Special Education ☐ Behavior Intervention ☐ Other special service

Does your child's teacher have concerns with your child's development in any of the following areas?

☐ Motor skills ☐ Social abilities ☐ Self-help skills ☐ Learning abilities

Comments: _____

_____

_____

_____

Social Emotional Development
Does your child interact well with others? N
Does your child have any trouble making friends? N
Fears, Coping behaviors: Does your child have difficulty calming himself/herself when upset? N
Additional comments: _____
_____

Behavior
Please check any of the following that apply to your child:
☐ Cries often ☐ Dislikes hair brushing ☐ Frequent temper tantrums ☐ Dislikes tooth brushing ☐ Avoids touch from others ☐ Trouble following directions ☐ Dislikes playground equipment ☐ Trouble with changes in routine ☐ Seems to be "on the go" ☐ Clumsy ☐ Rocks self ☐ Weak muscles ☐ Sensitive to light ☐ Picky eater ☐ Sensitive to Sound ☐ Mouths objects ☐ Poor attention span

FEEDING HISTORY
Difficulty latching to bottle or breast? N Bottle/Nipple Type: _____ If so, please explain: _____
☐ Fed self independently ☐ Weaned from bottle/breast
Able to use: ☐ open cup ☐ spoon ☐ straw
Any difficulty? ☐ Swallowing ☐ Chewing ☐ Drinking ☐ Blowing ☐ Drooling ☐ Orally Defensive
If so, explain: _____
Food Allergies: _____
Favorite Foods: _____
Aversive Foods (if any): _____

LANGUAGE DEVELOPMENT
Age when your child spoke first word: _____combined words: _____ spoke in sentences: _____
What was your child's first word(s)? _____
First sentence? _____
Which sounds (if any) are of concern? _____
How many words can your child say? (List if fewer than fifteen): _____
_____
How many words are your child's sentences? _____ _
Does your child have any difficulty understanding you? N f yes, please describe: _____
_____ _____
Does your child have difficulty following directions? N (Describe): _____
_____
Any speech or hearing problems in the immediate or extended family (explain)? _____
_____
Has or does anyone receive services? N