Aultman Speech Therapy Services, LLC
4805 West 4th Street Hattiesburg, MS 39402
668 Old Salt Rd Sumrall, MS 39482
Phone: 601-270-6968 Fax: 601-336-5255
office@aultmanspeechtherapy.com
www.aultmanspeechtherapy.com

Information & Authorization Form For Dyslexia Evaluation/Treatment

Patient's Name:	**Date of Birth:**	**Gender:** ☐ Male ☐ Female
Guardian's Name/Relation:	**Phone #:** home: cell:	
Physical Address:	**City/State/Zip:**	
Mailing Address: (If different from above)	**City/State/Zip:**	
Emergency Contact Name/Relation (if above cannot be reached):	**Emergency Contact #:**	
Email Address:		

Primary Care Doctor:	**Doctor's Phone #:**

Does your child already receive speech/language therapy? □ No □ Yes

Does your child have an IEP? □ No □ Yes If yes, with whom?

Authorization of Services

I hereby authorize to Aultman Speech Therapy Services, LLC's Speech-Language Pathologists and Speech-Language Pathology Aides to screen, evaluate, and treat the above named patient as the need is indicated by his/her attending physician. I authorize Aultman Speech Therapy Services, LLC to request and/or release Protected Health Information including medical records, treatment records, diagnostic records, and IEPs as necessary to individualize therapy and obtain insurance prior authorization. This includes but is not limited to physicians, teachers, other school representatives and other therapists. I also authorize Aultman Speech Therapy Services, LLC to take photographs of above named patient if needed to be used as part of his/her Protected Health Information that may be released as indicated above.

_____ _____

Signature of Parent or Legal Guardian Date

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Case History Form for Dyslexia

Patient Name:	**School/Current Grade:** If homeschooled-what program is used:

Describe your main concerns (please include when the problem was first noticed, who noticed, and where/when the problem occurs)

Has your child's doctor noticed or been notified of these concerns? If yes, what were his/her recommendations?

Please provide a summary of child's educational history (grades failed/"held back", tutoring received, accommodations received, teacher's concerns, areas of difficulty, IEP, etc):

What is his/her attitude toward school?

Does the child receive special services from a physician or agency? □Yes □No
If yes, please list name of physician or agency and type of services.

Family History

Please list all of the people who live in the same home as the child:

Name	Age	Relationship to child

Are there family circumstances that would be helpful to share with your therapist? (custody arrangements etc)

Are there any other languages spoken in the home? If yes, which languages and how often and by whom?

Do any other family members have speech, language, or related difficulties or disorders (ADHD, autism, etc)?

What do you believe Aultman Speech Therapy Services, LLC can do for your child?

Medical/Developmental History

Were there any illnesses or complications during pregnancy, labor, or delivery? □No □Yes
If yes, please describe:

Length of Pregnancy (In Weeks): _____ Length of Labor: _____

Patient Name:_____

Type of birth: □Induced □Vaginal □Scheduled C-Section □Emergency C-Section
How long was labor? _____
Was delivery □ head first, □ feet first, or □ cesarean?
Did your child have trouble starting to breathe or cry? □No □Yes
Did your child turn yellow? □No □Yes
Did your child turn blue? □No □Yes
Did your child have convulsions? □No □Yes

Did your child have birth defects? □No □Yes If yes, please describe:

Did your child spend any time in NICU? □No □Yes If yes for how long and for what reason:

Birth Weight: _____ pounds _____ounces

How was your child fed? □ Breast □ Bottle
Did your child have sucking or feeding difficulty? □No □Yes

Describe any serious illnesses, injuries, or medical procedures your child has experienced (please include dates)

Has your child been diagnosed with a Developmental Delay (late talking, walking, etc.)? Explain:

Has your child had reoccurring ear infections? □Yes □No
If yes how many and were tubes necessary? □Yes □No If yes, when:

Does your child have any allergies? □Yes □No If yes, what is he/she allergic to?

Is the child in good health at this time?
State any physical handicaps:

List any routine medications your child is currently taking or has taken long term:

Medication	Dosage	Reason for taking

Please mark Yes or No for the following questions:

Has your child's hearing been screened?	□Yes □No	Does your child use a hearing device?	□Yes □No
Has your child's vision been screened?	□Yes □No	Does your child wear glasses/contacts?	□Yes □No
Tonsils removed/Age	□Yes □No	Adenoids removed/Age	□Yes □No
Autism Spectrum Disorder	□Yes □No	Attention Deficit Disorder/Type	□Yes □No
Tied tongue	□Yes □No	Feeding difficulties/Describe	□Yes □No
Asthma	□Yes □No	Anxiety	□Yes □No
Cerebral Palsy	□Yes □No	Seizures/Type	□Yes □No

Patient Name:_____

Meningitis/Age	□Yes □No	Brain Injury/Age	□Yes □No
Behavior/Emotional Disorder/Type	□Yes □No	Cleft Lip or Cleft Palate (Circle One)	

List and explain any problems not listed above:

Please explain if you answered "yes" to any of the above:

At approximately what age did your child do the following:

Sit up _____ Crawl _____ Walk _____ Say First Word _____

Combine 2 words _____ Potty Trained Day _____ Potty Trained Night _____

Speak in sentences _____ Read words _____ Read sentences _____ Write words _____

Write sentences _____ Rode a tricycle _____ Rode a bicycle _____

Fed Self: Spoon _____ Fork _____

Please circle Y (yes) or N (no) to the following questions:

□Yes □No	Do you (or others) have difficulty understanding your child's speech?
□Yes □No	Does your child repeat words or phrases over and over?
□Yes □No	Does your child have difficulty word finding?
□Yes □No	Does your child respond correctly to yes/no questions?
□Yes □No	Does your child respond correctly to who, what, when, where, and why questions?
□Yes □No	Does your child have trouble following directions?
□Yes □No	Does your child enjoy playing with his/her same age peers?

Additional Questions for School Age Children:

□Yes □No	Does your child have difficulty reading grade-level passages?
□Yes □No	Does your child have difficulty spelling?
□Yes □No	Has your child previously been screened or evaluated for speech/language? If yes, please note the place and summarize the findings.
□Yes □No	Has your child previously been screened or evaluated for dyslexia? If yes, please note the place and summarize the findings.

Describe your child's strongest skills and personality traits(favorite hobbies, subject, etc):

Please list any other information that you feel would be helpful:

_____ _____ _____

Signature of Parent or Legal Guardian Relationship Date

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SPEECH THERAPY INFORMATION REQUEST

Beneficiary Name: _____ Date of Birth: _____

Clinical Speech Therapy Provider: **Aultman Speech Therapy Services, LLC**

Educational Agency: _____

I give consent for the educational agency listed above to release information regarding my child to the above named clinical speech therapy provider.

_____ _____
Parent or Legal Guardian Signature Date

***Educational Agency fills out below this line:**

The above named beneficiary does **NOT** have an Individualized Education Plan (IEP) in place at this time because (please check one of the following):

☐ Child has been referred to his/her local school district for testing but a comprehensive evaluation has yet to be scheduled by the school district.

☐ Child has been referred to his/her local school district for testing and a comprehensive evaluation has been scheduled for ____/____/_____.

☐ Child was screened by his/her local school district on ____/____/_____ but did not qualify for further testing by the school district.

☐ Child was evaluated by his/her local school district on ____/____/_____ and qualified for educational services; however, the parent did not consent to placement in the speech/language program and has chosen to receive services elsewhere.

☐ Other: _____

_____

*By signing below, I hereby attest that the above information is true and accurate.

_____ _____
School Representative Signature/Title Date

Warning Signs of Dyslexia

Your child may need further testing if he/she has 3 or more of the following warning signs:

*****PLEASE CHECK ALL THAT APPLY TO YOUR CHILD AND RETURN WITH PAPERWORK*****

- Delayed speech
- Mixing up the sounds or syllables in long words
- Articulation difficulties (r-l, m-n, s-sh-ch) and worked with a speech therapist
- Early stuttering or cluttering
- Chronic ear infections
- Constant confusion of left versus right
- Late establishing a dominant hand
- Difficulty learning to tie shoes
- Trouble memorizing his address, phone number, or the alphabet
- Can't create words that rhyme
- A close relative with dyslexia or history of reading difficulties
- Dysgraphia (slow and difficult to read handwriting)
- Letter or number reversals continuing past the end of first grade
- Extreme difficulty learning cursive
- Slow, choppy, inaccurate reading:
    - guesses based on shape or context
    - skips or misreads prepositions (at, to, of)
    - Ignores suffixes
    - can't sound out unknown words
- Poor spelling
- Often cannot remember sight words or homonyms
- Difficulty telling time on a clock with hands
- Trouble with math
    - memorizing multiplication tables
    - memorizing a sequence of steps
    - directionality
- Extremely messy bedroom, backpack, and desk
- Dreads going to school
    - complains of stomach aches or headaches
    - may have nightmares about school
- Word retrieval difficulty when speaking
- Extremely poor written expression
- Unable to master a foreign language (if applicable)
- Difficulty reading printed music (if applicable)
- Homework takes extremely long time; child is frustrated and unable to complete homework without assistance

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Communication Authorization

Patient Name: _____

Patient Date of Birth: _____

Parent/Legal Guardian Name (Printed): _____

Email address: _____

Cell phone #: _____

* I authorize Aultman Speech Therapy Services, LLC to send a **Patient Portal** email to the above email address. Once you receive the email, you will set your password using the link provided. (The email address listed above is your user name.) **Save the link to access the secure Patient Portal** for access to your child's Speech Therapy records (Protected Health Information) which can be used for personal viewing or to share with others needing his/her therapy records.

* I authorize Aultman Speech Therapy Services, LLC to email and/or text information regarding appointments, home exercise programs, and other information as needed. Emails and/or texts will be general and will not include any Protected Health Information.

-If home exercise programs, appointment reminders, etc. need to go to a different email/text than listed above (ex. other parent, grandmother, aunt, sitter), please indicate in the space below the person's name, relationship and email and/or cell #.

Parent/Legal Guardian Signature: _____ Date: _____

*By signing above, I affirm that I am the parent or legal guardian of the above named patient.

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SIGNATURE of ACCEPTANCE and ACKNOWLEDGEMENT

Insurance Authorization Policy

I, the undersigned, authorize payment of medical benefits to Aultman Speech Therapy Services, LLC for any service rendered to the patient by the Speech-Language Pathologist. I understand that I am financially responsible for any amount not covered by my insurance policy. I also authorize you to release my insurance company information concerning healthcare, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.
**I understand that it is MY responsibility to watch my EOB (Explanation of Benefits) from my insurance for the amount "owed to provider." I understand and agree to pay the amount owed. I understand it is my responsibility to contact Aultman Speech Services, LLC for any questions regarding insurance.

_____ _____

Signature Date

Privacy Policy

I have been provided a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to read and understand. I give consent to Aultman Speech Therapy Services, LLC to use and disclose protected health information about the patient for treatment, payment, and healthcare operations.

_____ _____

Signature Date

Financial Policy

I have been provided a copy of the Aultman Speech Therapy Services, LLC Financial Policy. I understand that I, the patient or patient's representative, am responsible for payment of all charges for services rendered including what is not covered by insurance (co-pays, deductible, co-insurance, etc). I also acknowledge that non-payment of my account may result in dismissal from treatment. **I agree to make monthly payments on any balance owed. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.

_____ _____

Signature Date

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Financial Policy

- **Payment:** Payment is due when services are rendered, however we do allow monthly payments as long as payments are being made. If insurance is being filed, you will be responsible for any co-pay, co-insurance and deductible amounts. It is your responsibility to watch your EOB (Explanation of Benefits) from your insurance for the amount "owed to provider." It is also your responsibility to contact your insurance company and/or Aultman Speech Therapy Services, LLC if have any questions. If payments are not being received on a timely basis, services may be discontinued permanently or until the payments are caught up. In the event your account is turned over to collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs. **Payment for Dyslexia Evaluations are required to be paid in full at time of service.

- **Authorizations:** Some insurance plans require a prior authorization for services. Aultman Speech Therapy will attempt to obtain prior authorization, if denied, we will go through the appeal process one time at which point you will be responsible for obtaining prior authorization.
Medicaid requires a doctor's visit **EVERY 6 months to be approved for services.

- **Participating Insurance Plans:** If Aultman Speech Therapy does not participate in your insurance plan, you will be responsible for filing your own claims and paying in full at the time service is rendered.

- **Non-covered services/denied charges:** Certain services may be considered non-covered services or may be denied as not medically necessary by your insurance carrier. If your physician feels these services are needed and they are performed, you are obligated to pay for these services in full should your insurance carrier deny payment.
**Dyslexia Evaluations and Treatment for Dyslexia are considered non-covered services by insurance.

- **Cancellation/"No Show" Policy:** Please notify your therapist as soon as possible if you will be unable to keep your appointment. Failure to show up for three consecutive appointments with no prior notice may result in dismissal of services.

- **Insurance policy changes:** If you obtain an additional policy or switch your current insurance company or make changes to your policy, please notify Aultman Speech Therapy as soon as possible. Failure to notify Aultman Speech Therapy of changes could result in extra charges to you.

- **Termination of Services:** Notify Aultman Speech Therapy if you choose to terminate services. You will be responsible for payments of all services until the date we are notified.

****Parent/Guardian Copy****

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Privacy Policy

Objective

Aultman Speech Therapy Services, LLC has adopted a policy that protects the privacy and confidentiality of protected health information (PHI) whenever it is used by company representatives. The private and confidential use of such information will be the responsibility of all individuals with job duties requiring access to PHI in the course of their jobs. You may request a detailed copy of our HIPAA Notice of Privacy Practices Policy.

Protected Health Information (PHI) Defined

PHI refers to individually identifiable health information, including but not limited to demographics, medical conditions, health status, claims experience, medical histories, physical examinations, genetic information and evidence of disability.

The HIPAA Privacy Compliance Officer

Aultman Speech Therapy Services, LLC has a designated HIPAA compliance officer (HCO), and any questions or issues regarding PHI should be presented to the HCO for resolution. The HCO is also charged with the responsibility for:

- Issuing procedural guidelines for access for PHI.
- Developing a matrix for personnel who will need access to PHI.
- Developing guidelines for describing how and when PHI will be maintained, used, transferred or transmitted.

Annual Activities Necessitating Use of PHI and Your Rights under the HIPAA Privacy Rule

Annually or more frequently as necessary, Aultman Speech Therapy Services, LLC provides assistance in insurance claims problem, resolution, and explanation of benefits issues; assists in coordination of benefits with other providers; update medical records as needed. Some or all of these activities may require the use or transmission of PHI. Thus, all information related to these processes will be maintained in confidence, and employees will not disclose PHI from these processes for employment-related actions, except as provided by administrative procedures approved by the HCO. General rules follow:

- Disclosures that do not qualify as PHI-protected disclosures include:
  - Disclosure of PHI to the individual to whom the PHI belongs.
  - Requests by providers for treatment or payment.
  - Disclosures requested to be made to authorized parties by the individual PHI holder.
  - Disclosures to government agencies for reporting or enforcement purposes.
- Information regarding whether an individual is covered by a plan for claims processing purposes may be disclosed.
- Information is being furnished for claims processing involving workers' compensation, ADA or FMLA status.

You have a right to request in writing a copy of your PHI unless otherwise prohibited by federal law.

Records Retention

Personnel records and disclosures of PHI will be maintained for a period of six years as required by federal law, unless a state law requires a longer retention period. Records that have been maintained for the maximum interval will be destroyed in a manner to ensure that such data are not compromised in the future in accordance with the company record destruction policy.

****Parent/Guardian Copy****