Phone: 601-270-6968 Fax: 601-336-5255
Email: office@aultmanspeechtherapy.com
Website: www.aultmanspeechtherapy.com

New Patient Intake Packet for Speech-Language Therapy

(Please print clearly)

Patient Name:	Date of Birth:	Gender: ☐ Male ☐ Female
Guardian Name and Relationship to Patient:	Phone #: home: cell:	
Physical Address:	City/State/Zip:	
Mailing Address: (If different from above)	City/State/Zip:	
Email address for Patient Portal:		

Emergency Contact (must be different than parent/guardian listed above):

Name:_____ Relationship to Patient:_____

Phone #: _____ May we disclose your child's treatment and health information to this person? ☐ Yes ☐ No

Primary Care Doctor (doctor you will sign off on your therapy):	Doctor's Phone #:

Primary Insurance Company:	Insurance Policy #:
Policyholder's Name: Relationship to Patient:	Policyholder's Date of Birth: Policyholder's SSN:
Policyholder's Employer:	

Secondary Insurance Company (if applicable):	Secondary Insurance Policy #:
Secondary Insurance Policyholder's Name: Relationship to Patient:	Secondary Policyholder's Date of Birth: Secondary Policyholder's SSN:
Secondary Insurance Policyholder's Employer:	

**We will need a copy of the front and back of the insurance card(s). You can send copies with this paperwork packet, email to office@aultmanspeechtherapy.com, text a screenshot to 601-270-6968, or fax to 601-336-5255.*

Patient Name: _____

Requested Location for Services: ☐ Hattiesburg Office ☐ Sumrall Office

☐ Daycare/School that we currently service _____

Requested time for services: ☐ morning ☐ afternoon
**this is not a guarantee of availability-we will contact to offer what times are available*

Does your child currently receive speech/language therapy? □ No □ Yes
If yes, provider/clinic name: _____

Has your child received speech/language therapy in the past? □ No □ Yes
If yes, provider/clinic name: _____
Dates of previous speech/language therapy: _____

Does your child have an IEP? □ No □ Yes If yes, with whom?
**Please provide a copy of your child's IEP or complete the attached form so that we can request a copy from the school district.*

Is your child currently enrolled in school? ☐ Yes ☐ No
Name of School: _____ Current Grade: _____
If homeschooled-what program is used? _____
Has your child repeated a grade? ☐ Yes ☐ No If yes, which grade? _____

Does your child receive any special services from school, a physician, or agency (special education teachers, audiologists, psychologists, ABA therapy, etc)? ☐ Yes ☐ No

If yes, list the provider and type of services.

Please describe any concerns you have about your child's communication skills.

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

How do you think we can best support your child? (Feel free to share your goals, expectations, or any strategies that have worked well in the past.

Patient Name: _____

Family Information-Please list everyone who lives 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?

Other languages spoken in the home? If yes, which languages, how often and by whom?

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

Medical/Developmental History

How would you classify your child's general health? ☐ Good ☐ Fair ☐ Poor

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

Birth weight: _____pounds _____ounces

Check **ALL** that apply:
☐ Eclampsia ☐ Pre-eclampsia ☐ Gestational Diabetes ☐ Multiple Births ☐ Premature Labor
Was pregnancy full term? ☐ Yes ☐ No Comments: _____
Type of birth: ☐ Induced ☐ Vaginal ☐ Scheduled C-Section ☐ Emergency C-Section
Any complications following birth? (convulsions, turning blue, turning yellow, breathing, etc): _____
_____
Did your child spend time in NICU? ☐ Yes ☐ No If yes, how long and reason: _____
Does your child have any birth defects? ☐ Yes ☐ No If yes, describe: _____

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
Autism Spectrum Disorder	□Yes □No	Attention Deficit Disorder/Type	□Yes □No
Asthma	□Yes □No	Anxiety	□Yes □No
Cerebral Palsy	□Yes □No	Seizures/Type	□Yes □No
Meningitis/Age	□Yes □No	Brain Injury/Age	□Yes □No
Behavior/Emotional Disorder/Type	□Yes □No	Cleft Lip or Cleft Palate? (Circle if yes)	----------
Tonsils removed/Age	□Yes □No	Adenoids removed/Age	□Yes □No

Patient Name: _____

Does your child have? (circle your answers) If yes, please also circle how often.

Frequent Colds	Yes	Sometimes	Frequently	No
Tonsillitis/Adenoiditis	Yes	Sometimes	Frequently	No
Nasal Congestion	Yes	Sometimes	Frequently	No
Halitosis	Yes	Sometimes	Frequently	No
Rhinitis	Yes	Sometimes	Frequently	No
Sinusitis	Yes	Sometimes	Frequently	No
Bronchitis	Yes	Sometimes	Frequently	No
Pneumonia	Yes	Sometimes	Frequently	No

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

Has your child had recurring ear infections? ☐ Yes ☐ No

If tubes were necessary, when was the surgery? _____

Describe any serious illnesses, injuries, or medical procedures (including dates):

List any other medical diagnoses that your child has and when they were diagnosed:

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

Medication	Dosage	Reason for taking

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

Does your child have any physical handicaps?

At approximately what age did your child do the following:

Sit up _____ Crawl _____ Walk _____ Say First Word _____ Combine 2 words _____

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

Write sentences _____ Rode a tricycle _____ Rode a bicycle _____

Fed Self: Spoon _____ Fork _____ Potty Trained Day _____ Potty Trained Night _____

Communication: Check **ALL** that apply:

☐ difficult to understand speech
☐ responds correctly to who, what, when, where, why, how questions
☐ responds correctly to yes/no questions
☐ has difficulty following directions
☐ has difficulty word finding
☐ repeats words and phrases over and over
☐ retrieves or points to common objects upon request (ex. ball, cup, shoes)

Patient Name: _____

Child's Primary Communication: ☐ Verbal ☐ Non-Verbal ☐ None

Methods of communication used:
☐ Vocalizations ☐ Single Words ☐ Two-word phrases ☐ Facial Expression ☐ Body Language
☐ Manual Sign Language ☐ Pointing ☐ Gestures ☐ Eye Gaze

Feeding/Oral Motor

Has your child ever been evaluated for tongue-tie? ☐ Yes ☐ No
If yes, by which specialist and what was the result of the evaluation?

Does your child currently have a tongue-tie? ☐ Yes ☐ No

Has your child ever had a swallow study? ☐ Yes ☐ No If yes, date: _____
Results of swallow study:

How was your child fed? ☐ Breast ☐ Bottle Until age: _____

Check **ALL** that apply:
☐ NO feeding difficulties DURING INFANCY
☐ baby gumming/chewing on nipple
☐ baby unable to hold pacifier
☐ poor weight gain or failure to thrive
☐ baby unsatisfied after prolonged feeds
☐ latching difficulties
☐ reflux type issues
☐ breast/bottle refusal
☐ baby falling asleep on breast/bottle
☐ prolonged feeds

Did your child use a sippy cup? ☐ Yes ☐ No If yes, until age: _____
Did your child use a pacifier? ☐ Yes ☐ No If yes, until age: _____ How often: _____
Did your child suck his/her thumb/fingers? ☐ Yes ☐ No If yes, until age: _____ How often: _____

Does your child have past or current difficulties with feeding and/or swallowing? ☐ Yes ☐ No

Check **ALL** that apply:
☐ difficult transition from bottle/breast to cup
☐ difficulty transitioning to different food stages
☐ immature feeding pattern (only milk, purees, etc)
☐ sensitive to different tastes and textures of foods
☐ on-going reflux type issues
☐ food residue on tongue
☐ food aversions
☐ hyperactive oral sensory responses (gagging, vomiting, retching, etc)
☐ restrictive eater (less than 30 foods)
☐ pocketing of food in cheeks
☐ growth concerns

List any **CURRENT** difficulties with feeding and/or swallowing not listed above:

Patient Name: _____

Information on Sleep: (circle your answers)

Time child goes to bed _____ Time child wakes up _____ Total hours asleep _____

Check **ALL** that apply:

- ☐ sleeps hours expected for age but wakes up tired
- ☐ presence of drooling
- ☐ sleep is restless
- ☐ sleeps with mouth open
- ☐ sleep is calm
- ☐ wakes up constantly
- ☐ wakes up thirsty
- ☐ wakes up with a dry mouth
- ☐ snores
- ☐ other/comments:

Information about common occurrences during **DAYTIME**:

Check **ALL** that apply:

- ☐ drowsiness/sleepiness
- ☐ keeping mouth open
- ☐ dry or cracked lips
- ☐ wheezing or noisy breathing
- ☐ itchy nose
- ☐ blowing nose constantly
- ☐ daytime fatigue
- ☐ dark circles under eyes

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

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

Any other Developmental Evaluations or Testing your child has had-Age and Results:
(Psychological/Neuropsychological, Occupational Therapy, Physical Therapy, Developmental, etc)

Patient Name: _____

***Initial each line**

Authorization of Services

_____I hereby authorize Aultman Speech Therapy Services, LLC's Speech-Language Pathologists, Speech-Language Pathology Aides, and/or Speech-Language Pathology students to screen, evaluate, and treat the above-named patient as the need is indicated by his/her attending physician. I authorize Aultman Speech Therapy to request and/or release Protected Health Information including medical records, treatment records, diagnostic records, and IEPs as necessary to individualize therapy needs and/or 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 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.

Communication Authorization

_____I hereby authorize Aultman Speech Therapy Services, LLC to send a Patient Portal email as well as any other email communication to the email address listed on page one of the New Patient Intake Packet for Speech-Language Therapy. I understand that I will receive an email from Ensora Rehab Therapy Suite to set up a password for the Patient Portal. Once the password is set up, I understand that I will need to save the link to access the Patient Portal.

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Attendance Policy

_____I understand that if I am unable to keep my child's therapy appointment, I will notify my child's therapist by phone call or text as soon as possible. I understand that attendance is an important aspect of my child's progress and insurance may not continue to give authorizations for service if my child is missing sessions. **We know things happen and there are going to be some absences due to illness, planned vacations, and a few unexpected things. Please understand that we are a small business: our business and therapists are only compensated when your child attends their scheduled therapy sessions.*

_____I understand that arriving late may result in a shortened visit or the need to reschedule.

_____I understand that my child can be discharged from therapy if any of the following are met:

*Two (2) consecutive "No-Show" appointments (missed appointments with no previous notification)
*Four (4) cancellations within a 2-month period
*No progress and/or HEP (Home Exercise Plan) not being followed: Therapy is a partnership and all parties must work together for the child's success
*Delinquent payments on account

_____I understand that if I choose to terminate services, the request needs to be in writing. The termination of services request can be emailed to office@aultmanspeechtherapy.com or faxed to 601-270-6968.

Patient Name: _____

***Initial each line**

Insurance Authorization

_____I hereby authorize the release of any medical or other information necessary to process insurance claims and request payment of benefits to Aultman Speech Therapy Services, LLC for services rendered to the patient. I understand that I am financially responsible for any charges not covered by insurance.

_____I understand that insurance requires my child's physician to sign off on his/her plan of care. I understand that it is my responsibility to ensure my child has current appointments with the physician listed on page one of the New Patient Intake Packet for Speech-Language Therapy to discuss therapy so that insurance will continue to cover services. **If my child has MS Medicaid, I understand that they do require a visit with the physician **every 6 months**.

Financial/Payment Policy

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_____I understand that failure to pay my account may result in my account being turned over to small claims court. In such cases, I will be responsible for all additional costs incurred, including court fees, legal expenses, and other related charges.

I have been provided with a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to read and understand as well as a copy of the Authorizations and Policies that I have initialed above. I, the undersigned acknowledge and accept the authorizations and policies set forth by Aultman Speech Therapy Services, LLC. I understand that my initials and signature indicate my agreement to the terms and conditions outlined in these forms.

_____ _____

Signature Date

*By signing, I confirm that I am the authorized parent/legal guardian for the child listed within these forms.

Phone: 601-270-6968 Fax: 601-336-5255
Email: office@aultmanspeechtherapy.com
Website: www.aultmanspeechtherapy.com

Teletherapy Informed Consent Form

(1) As defined by ASHA, "Teletherapy" or "Telepractice" is the application of telecommunications technology to the delivery of speech language pathology professional services at a distance by linking clinician to client for assessment, intervention, and/or consultation via interactive audio, video, or data communications. I understand that teletherapy can involve the communication of my medical/health information, both orally and/or visually.

(2) Teletherapy will occur in the state of MS (USA) and will be governed by the current laws of the state as applicable. I understand that the teletherapy services received will be the equivalent in quality of face-to-face sessions as mandated by *ASHA's Code of Ethics* and *Scope of Practice in Speech-Language Pathology*.

(3) The current laws that protect the confidentiality of my medical information also apply to teletherapy at the time of service rendered. Unless we explicitly agree otherwise, our teletherapy exchange is confidential. I will not include others in the session unless agreed upon, or as deemed necessary for treatment.

(4) I accept that teletherapy does not provide emergency services. If I am experiencing an emergency, I understand that I can call 911 or proceed to the nearest hospital emergency room for help.

(5) In the event our teletherapy is not in my best interests, my speech-language pathologist will explain that to me and suggest some alternative options better suited to my needs.

(6) I understand there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my SLP, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. I am responsible for information security on my computer.

(7) I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in teletherapy. I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, and (2) arranging a location within my home with sufficient lighting and privacy that is free from distractions or intrusions during my session.

I have read, understand, and agree to the information above.
I hereby grant consent to engage in teletherapy with Aultman Speech Therapy, LLC.

_____
Patient's Name

_____ _____ _____
Signature of Parent or Legal Guardian Date Phone number

Phone: 601-270-6968 Fax: 601-336-5255
Email: office@aultmanspeechtherapy.com
Website: www.aultmanspeechtherapy.com

Authority to Release and Obtain Information

I give Aultman Speech Therapy Services, LLC permission to release and exchange all medical, and/or special education/504 information and records on the person named below:

Patient Information

Patient: _____ DOB: _____

Requested by: Aultman Speech Therapy Services, LLC

Records requested from: _____

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

The above-named does **NOT** have an Individualized Education Plan (IEP) in place currently 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: _____

_____

_____ _____
Signature of Parent/Legal Guardian Date

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Parent/Guardian Copy

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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