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

# Information & Authorization Form For Speech-Language Therapy

| | | |
|---|---|---|
| **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 #:** |
| **Insurance Company Name:** | **Insurance Policy #:** |
| **Insured's Name: (If private insurance)** | **Insured's Date of Birth: (If private insurance)** |
| **Insured's Employer: (If private insurance)** | |

**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/give permission 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 IEP's as necessary to individualize therapy and obtain insurance prior authorization. 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 to his/her attending physician.

Guardian Signature: _____ Date: _____

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# Case History Form for Speech-Language

| **Patient Name:** | School/Current Grade:<br>If homeschooled-what program is used: |
|---|---|

Describe your main concerns (please include when the problem was first noticed it, who noticed it, and where 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 (audiologists, psychologists, special education teachers, etc)? □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)?

**Patient Name:**_____ 

**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: _____

Type of birth: □Induced □Vaginal □Scheduled C-Section □Emergency C-Section
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

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?

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 |

Is the child in good health at this time? □Yes □No If no, please describe:

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 |
| 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 One) | |
| Tonsils removed/Age | □Yes □No | Adenoids removed/Age | □Yes □No |

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 mark Yes or No for 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? |

**Patient Name:** _____ 

| | |
|---|---|
| □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? |

## Speech

At what age did he/she say words? _____ What were the words? _____
At what age did he/she start to name people and objects? _____
At what age did he/she have a name for everything? _____
At what age did he/she combine words into short sentences like "want drink" or "up daddy"? _____
At what age did he/she use more complete sentences? _____
Did speech learning ever seem to stop for a period of time? □No □Yes If so, please explain:

Does he/she understand what you say to him/her? □No □Yes
Does he/she seem to be aware of a speech difference? □No □Yes If so, please explain:

Has there been a change in the child's speech in the last six months? □No □Yes If yes, please explain:

Has the child ever talked better than he/she does now? □No □Yes If so, please explain:

## Feeding/Oral Motor

Has your child been previously evaluated for tongue-tie (before first birthday)? □No □Yes
If yes, by which specialist? (Lactation Consultant, Pediatrician, Family Doctor, etc.) _____
Was further evaluation recommended at that time? □No □Yes
Was referral to specialist given (Speech Language Pathologist, Primary Doctor, Ear, Nose, & Throat Doctor)? □No □Yes

Does your child currently have tongue-tie? □No □Yes

How was your child fed? □ Breast □ Bottle

Describe feeding difficulties DURING INFANCY? (check all that apply) □NO feeding difficulties DURING INFANCY

| | | | | | |
|---|---|---|---|---|---|
| | latching difficulties | | prolonged feeds | | baby gumming/chewing on nipple |
| | reflux type issues | | baby unsatisfied after prolonged feeds | | baby unable to hold pacifier |
| | breast/bottle refusal | | baby falling asleep on breast/bottle | | poor weight gain or failure to thrive |

**Patient Name:**_____ 

At what age did your child get off the bottle/breast? _____

At what age did your child use a sippy cup? □Yes □No

If yes, until what age? _____

Did your child use a pacifier? □Yes □No

If yes, until what age? _____ How often? _____

Did your child suck his/her thumb/fingers? □Yes □No

If yes, until what age? _____ How often? _____

Does your child CURRENTLY have any difficulties with feeding and/or swallowing? □No □Yes

| | | | | | |
|---|---|---|---|---|---|
| | on-going reflux type issues | | hyperactive oral sensory responses very gaggy, retching, vomiting) with feeding | | restrictive eater-food repertoire consists of less than 30 foods |
| | difficult transition from bottle/breast to cup | | sensitive to different tastes and textures of foods | | food aversions (refuses certain foods or entire classes of foods |
| | difficult transition from one food stage to next food stage | | pocketing of food in cheeks, under tongue, or palate after swallowing | | food residue on tongue after swallowing |
| | child stuck in immature feeding pattern (nutrition received primarily from milk, purees, and soft foods versus wide variety of regular food of appropriate consistency) | | growth concerns (consistently low weight and height percentiles) | | limited progression in chewing skills; child may swallow foods whole versus chewing |

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

**Information on Sleep:** (circle your answers)

| What time does your child go to bed? | | What time does your child wake up? | | *Hours asleep | |
|---|---|---|---|---|---|
| Is your child sleeping the hours expected for his/her age but waking up tired? | Yes | Sometimes | Frequently | No | Not Known |
| Is sleep calm? | Yes | Sometimes | Frequently | No | Not Known |
| Is sleep restless? | Yes | Sometimes | Frequently | No | Not Known |
| Does your child wake up constantly? | Yes | Sometimes | Frequently | No | Not Known |
| Does your child snore? | Yes | Sometimes | Frequently | No | Not Known |
| Does your child sleep with his/her mouth open? | Yes | Sometimes | Frequently | No | Not Known |
| Is there presence of drooling? | Yes | Sometimes | Frequently | No | Not Known |
| Does your child wake up with a dry mouth? | Yes | Sometimes | Frequently | No | Not Known |
| Does your child wake up thirsty? | Yes | Sometimes | Frequently | No | Not Known |

**Patient Name:**_____ 

**Information about common occurrences during DAYTIME:** (circle your answers)

| | | | | | |
|---|---|---|---|---|---|
| drowsiness/sleepiness | Yes | Sometimes | Frequently | No | Not Known |
| keeping mouth open | Yes | Sometimes | Frequently | No | Not Known |
| dry or cracked lips | Yes | Sometimes | Frequently | No | Not Known |
| wheezing or noisy breathing | Yes | Sometimes | Frequently | No | Not Known |
| itchy nose | Yes | Sometimes | Frequently | No | Not Known |
| blowing nose constantly | Yes | Sometimes | Frequently | No | Not Known |
| daytime fatigue | Yes | Sometimes | Frequently | No | Not Known |
| dark circles under eyes | Yes | Sometimes | Frequently | No | Not Known |

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 Guardian | Relationship | Date

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# SPEECH THERAPY INFORMATION REQUEST

Beneficiary Name: _____ Date of Birth: _____

Medicaid ID number: _____

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 Signature Date

The above named beneficiary does NOT have and 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

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# SIGNATURE of ACCEPTANCE

## Insurance Authorization

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.

_____ _____

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. I also acknowledge that non-payment of my account may result in dismissal from the practice.

_____ _____

Signature Date

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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.

12/17 Revised

**Parent/Guardian Copy**

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# Financial Policy

- **Payment:** Payment is due when services are rendered. If insurance is being filed, you will be responsible for any co-pay, co-insurance and deductible amounts at the time of service. If you are unable to pay these amounts at the time of service, your appointment may be rescheduled.

- **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.

- **Participating Insurance Plans:** If Aultman Speech Therapy does not participate in your insurance play, 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.

- **Cancellation/"No Show" Policy:** Please notify the speech-language pathologist 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.

**Parent/Guardian Copy**