Authorization Sheet

Child's Name:	**Date of Birth:**
Guardian's Name:	**Phone #:**
Address:	**City/State/Zip:**
Primary Care Doctor:	**Doctor's Phone #:**
Emergency Contact Name/Relation:	**Emergency Contact #:**
Email Address:	
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?

I hereby authorize/give permission to a license therapist to provide therapy services for me/my family member as the need is indicated by his/her attending physician, and/or use the protected health information. I also authorize the Speech therapy staff to screen and/or evaluate the above named patient.

Information to be disclosed: Medical Records Treatment Records Diagnostic Records IEP/504

I certify that the information given by me in applying for payment under Title XVIII, XIX and Medical Services Administration is correct, I authorize any hold of medical or other information about me to release any information needed for this or any related claims. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may inspect or copy the protected health information to be used or disclosed under this authorization. I request payment of authorized benefits be made on my behalf. I agree to the services being provided and assigned the benefits payable for therapy services to the therapist providing the services.
Finally, you may revoke this authorization in writing at any time by sending written notification to licensed therapist and it will be effective on the date of notification. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.
In consideration of these services received or to be received, I hereby authorize payment to licensed therapist for insurance benefits. I understand I am financially responsible to licensed therapist for charges not paid or covered by this authorization.

Signature: _____ Date: _____

Information and Consent Form

Patient Name:	Date of Birth:	Sex:

Family History of Speech/Language/Learning Disabilities Family Member Name:	Relationship to patient	Speech/Language/ Hearing/Other

Speech History	Age of Occurrence
Please guess or estimate what age your child did the following:	
said their first word (such as mama, dada, ball, bye)	
said two words together (such as me go, want drink)	
said three words together (such as me want drink)	

Health/Language History	Yes	No	Birth History	Yes	No
Do you feel your child has trouble talking?			Did mother have any health problems during pregnancy or delivery? If yes what?		
Do you feel your child has trouble hearing?			Did mother visit doctor fewer than 2 times during pregnancy?		
Has your child ever had ear infections? If yes, how many?			Was child born more than 3 weeks early? If yes, how many weeks early?		
Has your child ever had tubes placed in ears? If yes, when?			How was child delivered? Please circle: Vaginal or C-Section **How much did child weigh at birth?** _____		
Does your child wear glasses?			Was child ever in neonatal intensive care unit (NICU)? If yes, for what reason?		
Does your child have Asthma, allergies or sensitivities?			**Developmental History**	**Yes**	**No**
Is your child on any medications? List:			Was your child late sitting up?		
Does your child have difficulty following directions? (get your shoes, shut the door)			Was your child late crawling?		
Does your child have trouble getting enough air for talking?			Was your child late walking?		
Does your child repeat words over and over?			Was your child late talking?		
Does your child use gestures more than talking?			Was your child late feeding themselves?		
Does your child use words to make wants and needs known?			Was your child late being toilet trained?		
Has your child ever had speech therapy? When and where?			Was your child late understanding directions?		
Does your child respond correctly to yes/no questions?			Was your child late dressing themselves?		
Does your child respond correctly to who/what/where / when/ why questions?			**Most recent Doctors Visit?** **Doctor:** **Where:** **When:**		

Additional Information (Check as many as applies)																				
Adenoidectomy		High fevers		Sleeplessness		Colds		Measles		Breathing difficulties
Poor eating habits		Running away		Nightmares		Flu		Seizures		Thumb/finger sucking
Tonsillitis		Meningitis		Refusal to obey		Mumps		Fighting		Easily frustrated
Chicken pox		Strong Fears		Tonsillectomy		Lying		Jealousy		Difficulty playing with others
Temper tantrums		Scarlet fever		Easily distracted		Stealing		Stubborn		Hurting other children
Strong dislikes		Head injury		Fatigue		Sinusitis				Poor eye contact

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

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ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY POLICY

I, _____, parent or legal guardian of_____ (patient name), have received a copy of Aultman Speech Therapy's Privacy Policy.

Name (please print): _____
Signature: _____
Date: _____