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
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 and Relation (if above cannot be reached):	**Emergency Contact #:**	

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 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/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 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 Speech-Language

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

Describe your main concerns (Please include when the problem was first noticed it and who noticed it.)

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

Patient Name:_________________________________

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 if yes)	-------------
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? □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:

**By signing below, I confirm that I am the Legal Parent or Guardian of this patient.

____________________________________ ____________________

Printed name of Parent or Legal Guardian Relationship

____________________________________ ____________________

Signature of Parent or Legal Guardian 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

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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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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 situation, 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

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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.

- **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.

- **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****