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

New Patient Intake Packet for Dyslexia Evaluation and/or 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

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.

Patient Name: _____

Case History for Dyslexia

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

Has your child's doctor noticed or been notified of these concerns? If yes, what are 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, etc):

What is his/her attitude toward school?

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: _____

Does your child have difficulty reading grade-level passages? ☐ YES ☐ NO

Does your child have difficulty spelling? ☐ YES ☐ NO

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

List any other information you feel would be helpful:

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

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)?

Patient Name: _____

Warning Signs of Dyslexia

Your child may need further testing if they have 3 or more of the following warning signs:

Please check all that you feel apply to your child:

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

Sign and add School/District Name if your Child has an IEP

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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

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. 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. 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 Dyslexia Evaluation and/or 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. I understand the Patient Portal is where I will receive access to my child's Evaluation and any Daily Notes if receiving treatment.

_____I hereby authorize Aultman Speech Therapy, any employees and Ensora Rehab Therapy (or other associated EMR) to send text messages to the number(s) listed on page one of the New Patient Intake form for Dyslexia Evaluation and/or Therapy.

Financial/Payment Policy

_____I understand that Dyslexia is not covered by insurance, and I am financially responsible for payment of all charges for services rendered. **Payment for a Dyslexia Evaluation is due at the time of service**.

****Financial/Payment Policy for Private Pay Dyslexia Treatment***

_____I understand that invoices will be emailed monthly from Ensora Rehab Therapy to the email address listed on page one of the New Patient Intake Packet for Dyslexia Evaluation and/or Therapy. If I prefer to receive both an email and a paper copy of the invoice, I understand that it is my responsibility to contact the Office Administrator to make this request. *******The high cost of postage has led to this change for our small business.*

_____I understand that I can call the Office Administrator at 601-270-6968 to get my current balance owed.

_____I understand that payment is required **in full** each month. Payments can be made by "Click to Pay" on your emailed invoice, your patient portal, credit card over the phone at 601-270-6968, or by check mailed to 4805 W 4th St Hattiesburg, MS 39402 ($20 fee for all returned checks).

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.

_____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.

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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