Patient Name:	Date of birth:
Gender: □Male □Female	Grade:
Doctor:	Date of last Dr. visit (sick or well):
School:	
Guardians:	
Address: City/State/Zip:	
Do you have insurance that you would like to file this evaluation under? □Yes □No If yes please fill out the following: Insurance Name:_____ Insurance Policy Number: _____ Insurance Phone Number:_____	
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 these concerns? If yes, what were his/her recommendations?	
Please provide a summary of child's educational history (grades failed/"heldback", tutoring received, accommodations received/teacher's concerns/areas of difficulty/etc): Does your child have an Individualized Educational Plan (IEP)? □Yes □No If yes, with whom? Please list contact information:	

Please list all 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)?

Relation to child	Related diagnosis/disorder

Describe any complications during pregnancy:

Describe any complications during labor/deliver:

Type of Birth: □Spontaneous (not induced) □Induced □Vaginal □Scheduled C-Section □Emergency C-Section □Other
_____

Gestational Age (In weeks):_____ Birth Weight: _____lbs _____oz
Did your child spend any time in NICU? □No □Yes
If yes for how long and for what reason:

Has your child's hearing been tested? □Yes □No
Does your child have a hearing problem? If yes, does your child have a hearing device?
Has your child's vision been tested? □Yes □No
Does your child have a vision problem? □Yes □No
Does your child wear glasses? □Yes □No

Describe any serious illnesses, injuries, or medical procedures your child has experienced (please include dates):
List any food or environmental allergies:
List any routine medications your child is currently taking or has taken long term please list mg and reason taken:
At what age did your child do the following:
□first word at _____months □Speaking in sentences _____ months/years □Reading Words _____ years □Writing words _____years □walk _____months □Crawl _____ months □ 2word combo _____months □Reading letters____ years □Reading sentences ___ years □Writing sentences ____years □sit up____ months □toilet trained _____years

Has your child's speech/language been evaluated before? If yes, please note the place and summarize the findings:
Describe your child's strongest skills and personality traits(favorite hobbies, subject, etc):
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 trouble following directions? □Yes □No Does your child respond correctly to questions (who, what, when, where?)? □Yes □No Does your child respond correctly to yes/no questions? □Yes □No
Please list any other information that you feel would be helpful:

Thank you for filling out this form about your child.

Authorization Sheet

Therapy Information and 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 be 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: _____

Warning Signs of Dyslexia

Your child may need further testing if he/she has 3 or more of the following warning signs:

*****PLEASE CHECK ALL THAT APPLY TO YOUR CHILD AND RETURN WITH PAPERWORK*****

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

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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 this office's Privacy Policy.

Name (please print): _____

Signature: _____

Date: _____