Speak To Me, Inc.

595 Morrison Farm Road ● Troutman, NC 28166 ● Ph: 704-301-2683 Fax: 704-360-4467
www.speaktomenc.com

Case History

Date: _______________

Child's Name: _________________________________ Age: ___________

DOB:____ Gender: ☐ Male ☐ Female

Completed by: _________________________________ Relationship to Child: ___________________

Child's Primary Language: ____________________ Language(s) Spoken at Home: _________________

Child's Address:____ City :_____________Zip:___________

Phone Number: _____________________________

Please describe why you are having your child seen for a speech-language evaluation (e.g. voice, stuttering, Expressive language delay (spoken language), receptive language delay (understanding), articulation, reading difficulty, etc):
____

____

____

How does the child usually communicate (gestures, single words, short phrases, sentences)? _______________

____

____

Has the child ever received speech therapy? ______________ If so by whom: _________________________

____

Why was therapy recommended: ____

____

How long did the child receive services: ____

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Educational Status:
Does your child attend daycare/school? ____ Yes ___No
If so, which daycare/school? ____ Grade: _______
Does your child have an IEP? ________________________________Expiration Date: ___________

Check any items that have been observed with your child or appear difficult for them:

Eating a variety of foods	Following directions or routines
Drooling	Combining words or verbalizing communication
Swallowing while eating or drinking	Understanding what he/she hears
Dysfluent or stuttering	Pronouncing words correctly
Expressing thoughts and ideas clearly	Answering questions correctly

Family History:

Father's Name:____

History of Speech Disorder: ☐ Yes ☐ No

Type of Speech Disorder (if applicable)____

Mother's Name:____

History of Speech Disorder: ☐ Yes ☐ No

Type of Speech Disorder (if applicable):____

Siblings and any history of speech disorder: ____

____

____

Any additional family history relevant to speech and language disorders:

____

____

____

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Physiological Information

Child's Current Health Status (please circle one): ☐Excellent ☐ Good ☐ Fair ☐ Poor

Does child have any current medical diagnoses? (e.g., autism, ADD/ADHD, etc)**:**
____

Is the child taking any medications (y/n)? If yes, please explain: _______________________________

____

Does your child have any known allergies: (y/n) If yes, identify: ___________________________

____

Date of most recent physical examination or doctor's visit: _____________________________________

Current Pediatrician's name: ___________________________________Phone: ____________________

Physician's Address: ____

Has your child had any of the following? (Please circle ALL that apply and list age of occurrence if applicable):

☐ Chicken Pox ☐ Measles ☐ Scarlet Fever ☐ Rheumatic Fever

☐ Pneumonia Influenza ☐ Asthma ☐ Hay Fever ☐ Earaches

☐ Diphtheria ☐ Encephalitis ☐ Mumps ☐ Meningitis

☐ Allergies ☐ High Fevers ☐ Whooping Cough

☐ Ear Infections ☐ Seizures ☐ Respiratory Illness

Surgeries/Infections:____

Hearing

History of ear infections? ☐ Yes ☐ No Please explain:________________________________

Has this child ever been seen by an Audiologist or had any otological care/surgery done in the past? If yes, please explain:____

Any hearing concerns/issues:____

Delivery:
Mother's health during pregnancy:____

Length of Labor:__________________________ Birth Weight:_______________________________

Was child born premature? ☐ Yes ☐ No

Delivery (check one): ☐ Vaginal ☐ Breech ☐ C-Section

Child's Condition at Birth: ☐ Jaundiced ☐ Blue ☐ Breathing ☐ Other

Feeding: ☐ Breast-fed ☐ Bottle-fed ☐ Nutritional Disturbances

Did your child require to stay in the NICU? (Neonatal Intensive Care Unit) ___ Yes ___ No (If so, how many days?) ______________________________

Any complications during pregnancy or delivery:____

____

____

Developmental Milestones (Please list approximate ages):

First tooth:______________ Sitting alone:_____________ Crawling:________________

Walking:________________ Dressing:_________________ Self-feeding:_____________

Potty trained:____________ First word:_______________

Additional Pertinent Information:____

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NOTICE OF PATIENT INFORMATION PRACTICES

SPEAK TO ME'S LEGAL DUTY

Speak To Me, Inc. is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein. We protect and establish appropriate safeguards to prevent, the unauthorized disclosure of PHI in accordance with state and federal law, including any regulations governing the security of PHI and the transmission, storage or maintenance of electronic data that contains PHI. Speak To Me does not use or disclose PHI in any manner inconsistent with the use and disclosure restrictions placed on the Covered Entity by HIPAA.

USES AND DISCLOSURES OF HEALTH INFORMATION

Speak To Me uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Speak To Me may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you. Access to confidential information is allowed only to staff that have an authorized business requirement to view the Confidential Information.

Please initial authorizing Speak To Me to:
Leave detailed voicemails about patient's treatment and any financial matters regarding this patient. _______
Send detailed e-mails about patient's treatment and financial matters. _______

Speak To Me may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law. In any other situation, Speak To Me's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may stop future disclosures at any time. We shall not use, publish, transfer, sell or otherwise disclose any Confidential Information gained by reason that is not directly connected with the performance of services contemplated hereunder except as provided by law; or in the case of Personal Information, with the prior written consent of the person or personal representative of the person who is subject of the Personal Information.
Speak To Me may change its policy at any time. When changes are made, a new Notice of Information Practices will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. You may also request, in writing, that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Speak To Me will consider all such requests on a case by case basis, but the practice is not legally required to accept them. Speak To Me will notify covered entity of any potential breach of security or privacy. For instance, where the PHI is subpoenaed, copied or removed by anyone except an authorized representative of Speak To Me.

CONCERNS AND COMPLAINTS

If you are concerned that Speak To Me may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact the owner at the phone number listed below. You may also send a written complaint to the US Department of Health and Human Services

Leslie Giambrone, Owner/President (704) 301-2683

Client Name: ____ Date:____________________________________

Legal Parent or Guardian Signature: ____

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Dear Parents,

Thank you for choosing Speak To Me, Inc. Our commitment at Speak To Me is to empower families to help their child effectively communicate. We want to provide the highest quality of therapy to your child in a fun learning environment. For this reason, we want to ensure that all of your child's insurance benefits are accurate and up-to-date. We are responsible for billing your insurance provider for services rendered. We ask that all parents/guardians let the office of Speak To Me know when there is a change in your insurance provider and/or renewal with your current insurance provider. Speak To Me will always put forth our best effort to work with you and your insurance carrier to ensure your child remains eligible to receive speech and language services.

Insurance Agreement and Parent Consent:

1. I hereby authorize Speak To Me, Inc., to bill my insurance provider or CDSA for services rendered. I understand that I am responsible for paying any deductibles and/or copays that may apply.
2. I understand that I am responsible for any payment for services that my insurance company or other state program (CDSA) does not cover**.**
3. I understand that if my insurance provider denies any claims, I as the parent/legal guardian will be responsible for payment of these services.
4. I understand that failure to provide updated insurance information to the Speak To Me, Inc. office may put my child's services on hold. I will let my therapist or the office of Speak To Me know when there has been a change in insurance information by providing an updated front/back copy of the new insurance card. I as the parent/guardian will be responsible for the payment of any services rendered if any claims are denied from my provider due to not following this policy.
5. I understand that if Medicaid is my insurance provider, benefits will be covered 100% of the payment for the evaluation and therapy and I will not be billed for services. I understand that this cost is only covered if my child remains eligible for services.
6. I understand that a licensed Speech Language Pathologist or Registered Speech Assistant will provide such care.
7. I recognize and agree that I have the right to refuse treatment or terminate services at any time by notifying Speak To Me, Inc. In addition, Speak To Me, Inc. may terminate services by notifying me of termination and the reason.
8. I understand that I am responsible for providing a safe and quiet working environment for the therapy session and for keeping appointments as scheduled. Three absences without prior notification, any presence of guns, alcohol, or drugs, or the inability of provide a quiet space will be grounds for discharge.

RELEASE OF MEDICAL RECORDS:

1. I consent and request that copies of my prior medical and therapy records be delivered to Speak To Me, Inc. if necessary, to establish or continue my therapeutic treatment plan.
2. I authorize Speak To Me, Inc. to release copies of my therapy records, or such portions that may be relevant, or reports or summaries thereof, to other healthcare providers and facilities, state agencies, insurance companies or other third party payers for the purpose of continuing and coordination my plan of treatment or obtaining payment for services.

As the parent or guardian, I have read the above information and fully understand the content of this consent and release and I accept all terms and conditions.

___________________________________ ______________________________________
Printed Name of Parent/Guardian Signature

___________________________________ ______________________________________
Date Child's Name

____ ______________________________________
Address of Authorized Representative Phone Number

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Consent and Release of Photographs/Videos

- I _____________________________ (client or parent/guardian name) give consent to Speak To Me or any party authorized by Speak To Me to photograph and/or video record

  _____________________________ (client name) in connection with his/her therapy sessions, for any purpose subject to the therapist's discretion including but not limited to educational publication, for teaching purposes, and demonstration of progression of his/her skills.

- I authorize Speak To Me to use pictures of ___________________________ (client name) for promotional purposes (ex. Brochures, website, etc.)

- I acknowledge that I will receive no financial compensation for providing consent since my participation with Speak To Me in providing my consent and release in voluntary.

- I hereby release Speak To Me, their contractors, their employees and/or third parties involved in the creation or publication of Speak To Me. Publication from any and all liability that may arise in connection with the expressed and implied use of all photographs and videos outlined in this form.

- I reserve the right to revoke this agreement at any time. I understand that my right to revoke must be done in writing.

- I am the client, parent or legal guardian of the person named below and have the legal authority to execute this consent and release.

___________________________________	______________________
Printed Name of Client	Date
___________________________________	______________________
Signature of Client or Legal Representative	Relationship to Client