CASE HISTORY QUESTIONNAIRE - CHILD

Thank you for taking time to respond to the questions below and sharing important information about your child and your family. Your responses will help me appreciate your child's strengths and weaknesses in order to address specific goals to increase their communication and/or swallow skills. Please answer ALL questions as honestly as possible. This will better help Kids and Adults Therapy Services cater to the specific needs of your child/children.

Child's Name: ____________________________________ DOB: ____________ Sex: ____________

Address:____

Name of Informant: _________________________________ Relationship to child: ______________

Contact Number: Home___________________ Work_________________ Cell__________________

Physician Name____________________________ Phone_______________ Fax_________________

How did you hear about us (circle)? Doctor Friend Family Member Coworker KATS Patient/Family School Email Website Insurance Ad (TV, Radio, Magazine)

REASON FOR REFERRAL

What prompted you to refer your child for a speech and language evaluation?

____

______ ____

____

What concerns do you have with your child's communication?

____

______ ____

What kinds of things have you tried to help your child resolve the issues?

____

______ ____

What outcomes would you like to see if your child qualifies to receive speech, language and/or swallow therapy? ____

____

Are you willing to incorporate suggested activities into your daily routine to help your child's progress? ____

PREGNANCY and CHILD BIRTH (if additional space is needed – use back side of paper)
Did you carry your child full term? Yes No

Number of weeks carried prior to delivery __________ Birth weight ________ Length ________

Did you have a natural birth? Or did you have a C-section

Any complications during pregnancy and/or the birthing process? Yes No

____
____
____

Were you in good health throughout your pregnancy? Yes No

Were you taking any medications during your pregnancy? Yes No

Did you consume alcoholic beverages at any time during pregnancy? Yes No

Did you use tobacco products during pregnancy? Yes No

Did you use illicit drugs prior to and/or during your pregnancy? Yes No

How long did mom stay in the hospital? ____________

How long did the child stay in the hospital? _________

Did mom and child leave the hospital together? Yes No

Were any follow-up doctor visits required? If so, what for? ________________________________
____

MEDICAL HISTORY
Has your child ever been hospitalized? If so, what was the reason?
____
____

Has your child had any serious injuries, illnesses, surgeries? If so, what were they?
____
____

Do you consider your child to be healthy now? Yes No

What is the date of the child's last doctors visit? ____________ Reason _____________________
____
Are immunizations up to date? Yes - No Explain ____
____

MEDICATIONS/DRUGS, FOODS and/or ENVIRONMENTAL ALLERGIES
Does your child have any known allergies? ____
____
____
____

Does your child get frequent ear infections? Yes No Dates___________________________

VISION/HEARING
Did your child pass the hearing test? Yes/No Date _________ Doctor __________________
Results ____

Does your child have tubes in the ears? Yes No
If so, how would you describe your child's hearing before/after the tubes were put in?
____
____

Is one ear better/worse than the other? Are the tubes still in?

FAMILY HISTORY
List names and ages of ALL siblings (please include half or step siblings)
____
______ ____
____
Who does your child live with? ____
____

If your child does not live with both parents, does the other parent have visitation rights?
____

Does anyone else in the family have the same difficulties that the child has?
____
______ ____

Do you have a system of consequences/rewards when your child misbehaves or does a good job? (please explain)
____
__ ____

DEVELOPMENTAL MILESTONES
AT WHAT AGE DID YOUR CHILD:
Babble__________ Say his/her first word____________ Put 2 words together ______________
String words together to from a sentence__________ Crawl_________ Walk_____________
Gain control of bowels/bladder ___________ Assist with dressing __________ Feed self ______

ORAL HYGIENE/FEEDING ISSUES
Is your child able to eat foods of varying consistency (thin, thick, chewy, crunchy etc.) without difficulty? (ie. Can they eat/drink liquids, yogurt, crackers, applesauce, ice cream, meat etc. without coughing, spitting, gagging, or choking?)
____
______ ____

Was your child bottle or breast fed? ___________ how long? _____________

Does your child continue to drink from a bottle? Yes No

Does your child resist you when feeding? (turn head away, fussy, pushes items away from face/ mouth, etc) Yes No Explain ____
____
____

Is your child a "Picky Eater", Prefer certain textures over others? Yes No
Explain ____
____
____

Does your child experience a loss of liquid from the lips when drinking from a cup/bottle?
Yes No

Does your child experience a loss of food when eating from a spoon/fork? Yes No

Does your child continue to use a pacifier? Yes No How often? _______________

Does your child breathe through his/her mouth or nose? Yes No

Do you have any concerns about how your child's mouth works for speech or eating?
____
____
____

ARTICULATION

Can you understand what your child says? Yes No

Describe what his/her speech sounds like. (i.e. unintelligible, garbled, mumbled, soft, broken/ incomplete etc.)
____
____

Can someone who is not familiar with your child understand him/her? Yes No

How does your child react when he/she is not understood?
____
____
____

What sounds can your child easily and clearly produce? (/p, b, m, d, t, k, g/)? Any other sounds?
____
____

LANGUAGE

Does your child understand you when you talk to him/her? Yes No

Does your child follow simple 1-2 step directions? (provide examples)
____
____

Does your child use words to name things around the house and/or people? (provide examples)

____
____

How many words is your child using right now? (list them)

____
_____ ____
____

Does your child use jargon (nonsense words)? Can you understand the content of what your child is saying to you? Yes No

Does your child put multiple words together when communicating? Yes No
(provide examples)

____
____

How does your child express his/her wants/needs? (provide examples)

____
____
____

Does your child use words or gestures more to communicate? How so?

____
_____ ____

DAYCARE

Does your child attend a daycare? Yes No Name? ______________________________

Does your child follow a routine well? Yes No

How much time does your child spend with other children? ___________________________

PRIOR THERAPY-SERVICES

Does your child receive any other therapy at this time? Yes No

Has your child received ST, OT, PT, music etc. therapy in the past? Yes No

If so, how beneficial was it for your child? ______________________________________
____

BILINGUAL QUESTIONS (if applicable)

What is your child's primary language? ____

What language does your child prefer to speak? ___________________________________

What language is spoken by other members of the household? ______________________

Does your child have the same difficulties speaking in both languages? Yes No
Please explain: ____
____
____

Do you have any comments you would like to share? ______________________________
____
____
____
____
____

By signing this case history I attest that I have answered all questions as honestly as possible. I also understand that all or most of the responses contained here may be used in patient related documentation to assist with the thorough evaluation of my child.

______________________________________ ____________________
Signature of Informant Date

____
Relation to Patient/Child

SPEECH - LANGUAGE SCREENING CONSENT FORM

NAME: ______________________________ DOB: ______________ GRADE: __________

TEACHER: ___________________________ SCHOOL/PROGRAM: _____________________

PARENTS: _____________________________________ PHONE: ____________________

ADDRESS: ____

This form constitutes a request for screening, with parent/guardian permission , to determine if my child is meeting/is in danger of meeting developmental guidelines in the areas of language comprehension and use, speech/articulation, voice, fluency and swallow function. I understand that the Screening is not a diagnostic tool; however, it may serve as informal representation of my child's speech-language development. Further assessment may be recommended per results obtained from the screening.

I, parent/legal guardian of ____________________________________, give permission for Kids and Adults Therapy Services, PLLC to complete a speech/language screening on my child. I understand that the results will be provided to me for review.

As a parent, I have the following concerns about my child's speech-language development:
____
____
____

Please select a choice and return to your child's teacher by ____________________________

☐ I GIVE consent for this screen

☐ I DO NOT GIVE consent for this screen

____ ________________________

Parent Signature Date

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.

KIDS AND ADULTS THERAPY SERVICES
dba KIDS AND ADULTS THERAPY SERVICES, PLLC

Notice of Privacy Practices

By signing this form, you acknowledge receipt of the Notice of Privacy Practices from the Kids and Adults Therapy Services dba Kids and Adults Therapy Services, PLLC. The Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to review it carefully. The Notice of Privacy Practices is subject to change. If the Notice is changed, you may obtain a revised copy via written or oral request.

I acknowledge receipt of the Notice of Privacy Practices from Kids and Adults Therapy Services dba Kids and Adults Therapy Services, PLLC.

Signature: ________________________ Date: ____________
(Client / Parent / Guardian)

Signature: ________________________ Date: ____________
(KATS office personnel)

Kids and Adults Therapy Services
dba Kids and Adults Therapy Services, PLLC

Financial Policy

All Private Pay, Co-Pay, Co-Insurance, and/or unmet deductible fees are to be paid prior to the start of therapy services unless previously discussed and an alternative payment plan has been finalized. All fees and/or unpaid balances must be settled and pain in full by the last session of each month. Any balance that has not been paid in full by the end of the month will be assessed a late fee of $25 on the 5th day of the following month and an additional $15.00 for each additional 7 days thereafter. Accounts past due in excess of 30 days will be assigned to a collection agency and therapy will be terminated immediately.

***NOTE: Evaluation reports, progress reports and any documentation of therapy services can only be released if all financial obligations have been met and the account is in satisfactory condition.**

Insurance Disclaimer:

Insurance benefits are not a guarantee of payment. All claims are subject to eligibility and based on plan provisions and limitations in effect at the time of services rendered. Any and all charges/ balances that are not covered by your insurance company are your responsibility and must be paid according to the financial policy.

Services not covered by insurance:

***These services are billed at the cash rate directly to the patient or guardian. Payment must be on file prior to delivery of special services.**

- Progress reports
- Consultations
- IEP meetings
- Travel to/from location of patient
- Missed appointments (see cancellation policy below)

Cancellation Policy:

The scheduling of times and days of therapy services was completed with your best interest at hand and according to your expressed availability. We understand that things do happen and emergencies do occur; however, we ask that you please make it a priority to attend all scheduled sessions. A 24 hour notice is required to cancel a scheduled appointment. Your account will be charged a $50.00 fee for all missed visits and/or last minute cancellations. Please note that this missed visit/cancellation fee cannot be billed to your insurance and will be the sole responsibility of the patient and/or parent/guardian. Exceptions will be taken into consideration on inclement weather days which resulted in a cancellation on the day of services.

No Call - No Show

A no-call/no show will incur a charge of $50,00 per each incidence and must be paid prior to the delivery of additional therapy services. If the patient should incur 2 No Call-No Show events the patient will be removed from the schedule. Said patient may be required to be reassessed upon return (Note: Re-evaluation may/may not be reimbursed by your insurance carrier. As a result, these fees must be settled on the day of service).

Vacation Leave

Vacation Leave is granted one (1) time per calendar year and must not exceed a week of missed sessions. Your previously scheduled times and days will be reserved for you during that time. Prior arrangements are required.

Your signature below denotes you have been informed and you agree with the Financial Policies and Procedures of Kids and Adults Therapy Services dba Kids and Adults Therapy Services, PLLC and you pledge to follow said procedures as agreed in this document.

____ ________

Signature of patient, parent/guardian Date

____ ________

Printed Name of signee Date

____ ________

Kids and Adults Therapy Services, PLLC Office staff Date

Authorization to Bill Insurance

SECTION 1: Patient Information

Last Name: ______________________ First Name: ______________________ Middle Initial: ________

DOB: ______________ SS#: ______________________ Daytime Phone: (________)______________

SECTION 2: Benefits and Billing Information

Please notify the front desk staff if your visit is related to an injury or accident

I. Does your insurance have alternative medicine benefits? Yes No

Who is your Primary Care Provider?: Dr. ______________________ Clinic Phone #: (_______)______________

Clinic Address: ______________________ City:______________ State: ______ Zip Code: ____________

Does your plan require you to have a referral from you Primary Care Provider to receive coverage? Yes* No

*If yes, which licensed provider were you referred to at our clinic?:______________________

II. Primary Insurance Company & Plan Name: ______________________

ID Number: ______________________ Group/Policy Number: ______________________

Name of Policy Holder: ______________________ Policy Holder's Date of Birth: ______________

The policy holder is my: ______________ (specify relationship) Policy Holder's Gender (circle): Male Female

Is your Primary Insurance Policy a (circle): POS PPO EPO HMO Don't Know Other (specify): __________

III. Secondary Insurance Company & Plan Name: ______________________

ID Number: ______________________ Group/Policy Number:______________________

Name of Policy Holder: ______________________ Policy Holder's Date of Birth: ______________

The policy holder is my: ______________ (specify relationship) Policy Holder's Gender (circle): Male Female

Is your Secondary Insurance Policy a (circle): POS PPO EPO HMO Don't Know Other (specify): __________

SECTION 3: Guarantor Information

This section must be completed if someone other than the patient is financially responsible for the patient's account.

Last Name: ______________________ First Name: ______________________ Middle Initial: _________

Address: ______________________ City: ______________ State: _______ Zip: ___________ Phone: (_______)___________

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed below.

X ______________________________ ____________________

Guarantor's Signature **Date**

I understand that all co-pays are due at the time of service and that I am financially responsible for all charges whether or not they are paid by my insurance. I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 1.5% per month. I further understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that some third-party payers may require that my medical information, including copies of treatment notes, be submitted along with requests for payment. I hereby authorize ***Kids and Adults Therapy Services dba Kids and Adults Therapy Services, PLLC*** to release all medical information necessary to secure payment of benefits from the third-party payers specified above, and I authorize the use of this signature on all related submissions. I understand that this information may include medical information related to drug and alcohol abuse, sexually transmitted diseases, HIV/AIDS and mental health. I understand that this authorization shall remain valid without expiration unless expressly revoked by me in writing.

X ______________________________ ____________________

Guarantor Signature Date

X ______________________________ ____________________

Guarantor Printed Name Date

____

Relationship to Patient/Representative Authority

CONSENT FOR PHOTOGRAPHY AND USE

ADVERTISING MEDIUMS

I, ____, hereby give my consent and authorization to
(Parent/Guardian and/or Adult Patient)

KIDS AND ADULTS THERAPY SERVICES dba KIDS AND ADULTS THERAPY SERVICES, PLLC
(agency listed above)

and grant permission, as indicated below, for my child/myself to be photographed with my knowledge and discretion, and to use my child's/my photograph in it's advertising and marketing purposes as follows:

Purposes:

________ Company Website

________ Newspaper advertisement or articles

________ Collateral marketing materials for the Agency (brochures, Rack Cards, etc)

________ Agency Billboards

________ Social Media Sites (Facebook, Twitter, Instagram, etc)

________ Other ____

I agree to allow the above listed agency to use my child's/my photograph (adult) for the indicated purposes without further consent. I also agree that I (or any family/friends) will not receive compensation for this service and that I have full rights to revolt my consent. If I revolt my consent I shall notify the Agency listed above in writing.

____ __________________
Parent/Guardian and/or Adult Patient Date

____ __________________
Kids and Adults Therapy Services, PLLC Representative Date