A to Z Speech Therapy PLLC
1660 Booker Dairy Road Smithfield, NC 27577
Phone: 919.938-3824 Fax 919.209.9736

Case History

Date: _____

Name of Person Completing Form: _____ Relationship to Child: _____

Legal/Parents Names: _____

Child's Name: _____ Date of Birth: _____ Sex ◯M ◯F

Address: _____ City, State: _____ Zip: _____

Phone Numbers: _____ _____ _____

What is your child's primary language?_____

Email address: _____

Child's Primary Care Physician and Insurance Information

Pediatrician/PCP: _____ Phone: _____

Insurance Type: ☐ Medicaid ☐ Blue Cross & Blue Shield ☐ United Healthcare ☐ Other: _____

POLICY Number (please include alpha characters) _____

GROUP Number (please include alpha characters) _____

Policy holder's name and date of birth:_____

Family Information/History

Siblings:	**Age**	**History of Speech Disorder?**
_____	_____	☐ yes ☐ no
_____	_____	☐ yes ☐ no
_____	_____	☐ yes ☐ no
_____	_____	☐ yes ☐ no

Prenatal and Birth History

Birth weight: _____lbs _____ounces Term: ☐ Full term ☐ Premature

Type of Delivery: ☐ Normal ☐ Breech ☐ Caesarian ☐ Instrument

Were there any unusual conditions that may have affected the pregnancy or birth?

_____

Medical History

Check if the child has had or currently has any of the following conditions:

☐ allergies ☐ ADD ☐ ADHD ☐ asthma ☐ head injury
☐ tonsillectomy ☐ sleeping difficulty ☐ ear tubes ☐ vision problems
☐ Other diagnosis_____

Surgeries: _____ Injuries: _____

Medications:_____

Hearing:

Has the child had ear infections: ☐ Yes ☐ No If yes, specify: _____

Has the child passed a hearing test within the past year? ☐ yes ☐ no

Hearing Concerns: ☐ Yes ☐ No, If yes, specify: _____

Developmental Milestones

Please indicate whether your child had typical development or delays in any of the following milestones:

Speech	☐ Achieved with normal limits	☐ Delay
Gross motor (walking, crawling, running)	☐ Achieved within normal limits	☐ Delay
Fine Motor(coloring, cutting, writing)	☐ Achieved within normal limits	☐ Delay

School History/ Childcare Information

School/Childcare: _____ Grade: _____

Special Services (Any therapies or accomodations): _____

Does your child receive Speech therapy in school: ☐Yes ☐No

If yes, how many times a week does your child receive Speech therapy:_____

Speech History

Please describe your child's speech: (check any that apply)

☐ Easily understood by everyone ☐Completely not able to understand child's speech

☐ Understood if listener knows topic or is familiar with the child ☐ Nonverbal

☐ Words understood now and then

Has your child had any previous speech therapy ☐ Yes ☐ No

What agency?_____

What concerns do you have regarding your child's speech and language?

☐ Speech is difficult to understand

☐ Child stutters or repeats words or sounds

☐ Difficulty understanding language i.e. following directions, identifying objects

☐ Difficulty with language expression i.e. answering questions, grammar, vocabulary

☐ Social communication (i.e. holding conversations)

Other:_____

CLIENT CONSENT AND AUTHORIZATION

1. **CONSENT FOR SERVICES:** I authorize A to Z Speech Therapy, PLLC to render therapy services to my child. I understand that care will be provided by an appropraitely trained and licensed health care professional. Treatment can be refused and/or terminated at any time by notifiying A to Z Speech Therapy in writing. In additon, A to Z Speech Therapy may terminate services by notification.
2. **AUTHORIZATION TO RELEASE INFORMATION/INSURANCE AGREEMENT:**We, at A to Z Speech Therapy, PLLC are aware that your child's speech and language therapy is your main priority. We are also aware that you would like us to bill your insurance company for services rendered by A to Z Speech Therapy, PLLC. With this billing option, we will submit your insurance company with any pertinent information (evaluation, treatment goals) needed to complete your insurance forms. If the insurance company denies all or part of your claims filed, therapy services may be put on hold until resolution of insurance billing.
3. **NOTIFICATION OF PHYSICIAN OR INSURANCE CHANGES:**I agree to notify A to Z Speech Therapy, PLLC of any changes in my child's **physician** or **insurance coverage** prior to the date of change.
4. **MISSED APPOINTMENTS POLICY:We** believe that a consistent schedule is very important to your child progress. If your child misses 3 or more consecutive therapy sessions; our office reserves the right to place your child's services on hold until the scheduling difficulties are resolved or to discontinue services if necessary.
5. **HIPAA NOTIFICATION ACKNOWLEDGEMENT:**I have received a copy and reviewed the **NOTICE OF PRIVACY PRACTICES** from A to Z Speech Therapy, PLLC and understand that this agency will comply with all HIPPA regulations.

I provide consent and authorization to release information for insurance/billing. I understand the notification or physician/insurance changes and missed appointments policy. I have received a copy of the HIPAA privcay notification.

_____ _____

Child's Name **Date**

_____ _____

Parent or Guardian's Name **Parent/Guardian Signature**

Dear Parent/Caregiver:

A to Z Speech Therapy, PLLC employs Speech-Language Pathology Assistants. The SLPAs will be directly supervised by our Speech-Language Pathologists. The SLP will be responsible for evaluating, establishing treatment plans, and instructing the SLPA on how to implement the treatment goals.

As do many other healthcare professionals, SLPs use SLPAs to implement treatment to their clients. The SLPA is registered with the North Carolina Board of Examiners for Speech-Language Pathologists and Audiologists and is supervised by a North Carolina licensed and ASHA certified Speech-Language Pathologist. Registered SLPAs must have an Associate's Degree in Speech-Language Pathology Assisting and have passed a competency exam in their field.

Our SLPAs may perform screening tests, provide therapy following a written plan established by the supervising SLP, and assist with scheduling and research activities. The supervision of the SLP involves both direct and indirect supervision of the SLPA.

Please contact the supervising SLP with any questions/concerns regarding your child's speech-language treatment plan and/or progress in therapy.

_____ _____

Child's Name **Date**

_____ _____

Parent or Guardian's Name **Parent/Guardian Signature**

Email Form To A to Z Speech Therapy, PLLC

A to Z Speech Therapy Notice of Privacy Practices

This Notice of Privacy Practices describes how A to Z Speech Therapy, PLLC may use and disclose your protected health information. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. This notice refers to practices followed by our medical and administrative staff, while you are a patient of A to Z Speech Therapy, PLLC. Uses and Disclosures of Protected Health Information

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to physicians or case managers involved in your care, etc. to ensure that the healthcare provider has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining payment for therapy may require that your relevant protected health information be disclosed to the health plan.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support business activities. These activities include, but are not limited to, quality assessment, employee review and training. We may disclose your health information to contractors, agents and other business associates who need the information in order to assist us with obtaining payment or carrying out our business operations. We may use your health information to communicate with you about treatment related benefits that could be of interest to you, to obtain payment for services or to conduct our business operations. However, we do not receive financial remuneration from a third party in exchange for making these communications. We may contact you by phone to schedule appointments or to follow up on our care. It is our policy never to leave vital health care information on voice mail. With your permission, we may share your health information with those you tell us will be helping your child or family member with her/her therapy program.

We may use or disclose your protected health information in the following situations without your authorization: as permitted by the HIPAA Privacy Rule, as required by law, emergencies, abuse or neglect, auditing purposes, research, criminal activity, workers' compensation, and other required uses and disclosures. A to Z Speech Therapy, PLLC may use or disclose your health information if we have removed information that might identify you.

As an employer-sponsored health plan, we will NOT use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes. A to Z Speech Therapy, PLLC does NOT sell or disclose your protected health information for external marketing or fundraising.

Any uses and disclosures other than those permitted by the HIPAA Privacy Rule will be made only with your written authorization. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time. You may request that we transfer your records to another person or organization by completing a written authorization form.

Rights of the Individual

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice at anytime. You may also request a current copy of our notice at any time. You have the right to inspect and copy your protected health information (fees may apply), whether in paper or electronic format.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. A to Z Speech Therapy, PLLC is not required to agree to your requested restriction except if you request that A to Z Speech Therapy, PLLC not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket. You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to receive an accounting of certain disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request. You have the right to receive notice of a breach if your unsecured protected health information has been breached.

You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control privacy of health information of minors unless the minors are permitted by law to act on their own behalf.

All requests must be made in writing. A to Z Speech Therapy, PLLC will consider all written requests on a case by case basis, but the practice is not legally required to accept them.

Concerns and Complaints

You can complain if you feel we have violated your rights by contacting us at the phone number below. You can file a complaint with the US DHHS OCR by sending a letter to 200 Independence Avenue, SW Washington, DC 20201. We will not retaliate for filing a complaint. ***Owner: Aliya D. Boone*** ***Phone: 919-389-8907***