SPEECH-LANGUAGE-HEARING CASE HISTORY FORM

Identifying and Family Information:

Child's Name: _____ Birthdate: _____ Sex: ☐ M ☐ F

Parent/Caregiver 1: _____ Daytime Phone: _____

Address: _____ Cell Phone: _____

_____ E-mail: _____

_____

Parent/Caregiver 2: _____ Daytime Phone: _____

Address: _____ Cell Phone: _____

_____ E-mail: _____

_____

Doctor's Name: _____ Doctor's Phone: _____

Child lives with (check one):

☐ Birth Parents ☐ Foster Parents ☐ One Parent

☐ Adoptive Parents ☐ Parent and Step-Parent ☐ Other _____

Family Background:

Marital Status: ○ Single ○ Married ○ Divorced ○ Separated ○ Windowed

Other children in the family:

Name	Age	Sex	Speech/Hearing Problems

Child's race/ethnic group:

☐ Caucasian, Non-Hispanic ☐ Hispanic ☐ African-American

☐ Native American ☐ Asian or Pacific Islander ☐ Other _____

Is there a language other than English spoken in the home? ☐ Yes ☐ No

If yes, which one? _____

Does the child speak the language? ☐ Yes ☐ No

Does the child understand the language? ☐ Yes ☐ No

Who speaks the language? _____

Which language does the child prefer to speak at home? _____

Speech-Language-Hearing

Do you feel your child has a speech problem? ☐ Yes ☐ No

If yes, please describe. _____

_____

_____

Do you feel your child has a hearing problem? ☐ Yes ☐ No

If yes, please describe. _____

_____

_____

Has he/she ever had a speech evaluation/screening? ☐ Yes ☐ No

If yes, where and when? _____

What were you told? _____

_____

_____

Has he/she ever had a hearing evaluation/screening? ☐ Yes ☐ No

If yes, where and when? _____

What were you told? _____

_____

_____

Has your child ever had speech therapy? ☐ Yes ☐ No

If yes, where and when? _____

What was he/she working on? _____

_____

Has your child received any other evaluation or therapy (physical therapy, counseling, occupational therapy, vision, etc.)? ☐ Yes ☐ No

If yes, please describe._____

_____

_____

_____

Is your child aware of, or frustrated by, any speech/language difficulties?_____

_____

What do you see as your child's most difficult problem in the home? _____

_____

What do you see as your child's most difficult problem in school?_____

_____

Prenatal/Birth History

Was there anything unusual about the pregnancy or birth? ❑ Yes ❑ No

If yes, please describe. _____

_____

_____

How old was the mother when the child was born? _____

Was the mother sick during the pregnancy? ❑ Yes ❑ No

If yes, please describe. _____

_____

How many months was the pregnancy?_____

Did the child go home with his/her mother from the hospital? ❑ Yes ❑ No

If child stayed at the hospital, please describe why and how long. _____

_____

_____

Check any items that apply regarding the birth of child:

During Pregnancy:

☐ Drug Use ☐ Alcohol Use ☐ Smoking ☐ Trauma/Injuries ☐ Significant Illness
☐ High Blood Pressure ☐ Hospitalization

Labor & Delivery:

Birth Weight: _____ lbs _____ ounces Term: ☐ Full Term ☐ Premature: ____ weeks

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

Complications After Birth:

☐ Difficulty Breathing ☐ Difficulty sucking ☐ Difficulty Feeding ☐ Seizures
☐ Jaundice ☐ HIV ☐ Sepsis ☐ Extended Hospital Stay - how long? _____

Medical History

Has your child had any of the following?

- ❑ adenoidectomy
- ❑ allergies
- ❑ asthma
- ❑ brain injury
- ❑ breathing difficulties
- ❑ chicken pox
- ❑ colds
- ❑ ear infections
  How often?_____
- ❑ ear tubes
  IF YES
  When?_____
  Which ear?_____
- ❑ encephalitis
- ❑ flu
- ❑ head injury
- ❑ high fevers
- ❑ measles
- ❑ meningitis
- ❑ mumps
- ❑ scarlet fever
- ❑ seizures
- ❑ sinusitis
- ❑ sleeping difficulties
- ❑ tonsillectomy
- ❑ tonsillitis
- ❑ vision problems

Other serious injury/surgery: _____

Is your child currently (or recently) under a physician's care? ❑ Yes ❑ No

If yes, why?_____

_____

Please list any medications your child takes regularly: _____

_____

_____

Developmental History

Please tell the approximate age your child achieved the following developmental milestones:

- _____ sat alone
- _____ crawled
- _____ stood alone
- _____ walked
- _____ babbled
- _____ said first words
- _____ combined words
- _____ used short sentences
- _____ grasped crayon/pencil
- _____ fed self
- _____ toilet trained
- _____ dressed self

Does your child...

- ❑ choke on liquids?
- ❑ choke on food?
- ❑ avoid food?
- ❑ follow a special diet?
- ❑ put toys/objects in his/her mouth?
- ❑ brush his/her teeth and/or allow brushing?
- ❑ use a pacifier?
- ❑ drool excessively?
- ❑ suck finger/thumb?

If under 4 years of age, how many words does the child say:
☐ 0-20 ☐ 21-50 ☐ 51-100 ☐ 101-150 ☐ 151-300 ☐ 301-500 ☐

Does the child spontaneously produce sentences of the following length:
☐ 2 words ☐ 3 words ☐ 4 words ☐ 5+ words

What percentage of the child's speech do you understand? _____%
How well do people outside of the family understand their speech? _____%

Current Speech-Language-Hearing

Does your child...

- ☐ repeat sounds, words or phrases over and over?
- ☐ understand what you are saying?
- ☐ retrieve/point to common objects upon request (ball, cup, shoe)?
- ☐ follow simple directions ("Shut the door" or "Get your shoes")?
- ☐ respond correctly to yes/no questions?
- ☐ respond correctly to who/what/where/when/why questions?

Your child currently communicates using...

- ☐ body language.
- ☐ sounds (vowels, grunting).
- ☐ words (shoe, doggy, up).
- ☐ 2 to 4 word sentences.
- ☐ sentences longer than four words.
- ☐ other _____.

Behavioral Characteristics:

- ☐ cooperative
- ☐ attentive
- ☐ willing to try new activities
- ☐ plays alone for reasonable length of time
- ☐ separation difficulties
- ☐ easily frustrated/impulsive
- ☐ stubborn
- ☐ restless
- ☐ poor eye contact
- ☐ easily distracted/short attention
- ☐ destructive/aggressive
- ☐ withdrawn
- ☐ inappropriate behavior
- ☐ self-abusive behavior

School History

If your child is in daycare/school, please answer the following:

Name of daycare/school and grade in school: _____
_____

Teacher's name: _____
_____

Has your child repeated a grade? _____
_____

What are your child's strengths and/or best subjects? _____
_____

Is your child having difficulty with any subjects? _____
_____

Is your child receiving help in any subjects? _____
_____

Is your child currently receiving any (ST, OT, PT) therapy services? _____
_____

Additional Comments

_____
_____
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Payment Policy & Fee Schedule

Thank you for choosing Wright Therapy Group to serve you. We are committed to providing you with the highest quality care. Please know that the timely payment of your bill is an integral part of our service and as such, this payment policy is an agreement between you and Wright Therapy Group for payment of services provided. By signing this policy, you are agreeing to pay for services provided to you or your family member. As a client of Wright Therapy Group, you are required to carefully review and sign our payment policy.

Please read the following information carefully:

1. All therapy fees (including session fees and/or co-pays, if applicable) are expected at time of service or no greater than 30 days following service date.
2. We accept the following payment methods currently: credit/debit card payments and checks.
(Checks should be made payable to Wright Therapy Group
3. We will provide you with an invoice outlining the services rendered and the amount charged.

Cancellation Policy:

Here at Wright Therapy Group, we value the services and time we provide to your child. Your child's attendance is important for communication success. As such, we have a cancellation policy of **12 hours** to notify your therapist of any cancellations. A charge of $25.00 will be deemed at our discretion if Wright Therapy Group is not notified within the 12-hour window or session is considered a "no show". This charge will not be covered by insurance and will be an out-of-pocket expense.

Please read and check all boxes to acknowledge understanding and the sign below:

☐ I understand that I am responsible for all costs / fees that any third-party payer (ex. insurance company, private school, etc.) does not cover. In the event that a third-party payer source determines that rendered therapy services are "not covered" or otherwise denied, I will be responsible for all outstanding charges. I understand that I will be billed accordingly and will be responsible for payment. I also understand that Wright Therapy Group will not become involved in disputes between insurance holder and your third-party source regarding uncovered charges or reasons for denial.

☐ I understand that if fees are not paid in full, treatment sessions may be postponed or canceled until payment is received.

☐ I understand that all returned checks will be subject to a $25 returned check fee. Charges incurred and not paid after 60 days may be turned over to a collection agency at the client's expense. Overdue accounts may also be reported to a Credit Bureau.

☐ I understand that I am responsible for all legal and collection fees, which Wright Therapy Group may incur if payment is not made in accordance with the terms and conditions herein.

☐ I understand that refunds will be issued only in instances of overpayment. All refunds will be processed within 14 days after the overpayment is discovered on the client's bill or at the time the refund is requested. Refunds for payments made with a credit/debit card will be credited back to the card used, all other refunds will be issued by a check. Clients who used a third-party source will not be issued a refund until full payment is received from the appropriate source.

☐ I, understand that all cancellations require 12 hours' notice and that there will be a $25 charge for any cancellations made less than 12 hours. This charge is my sole responsibility and will not be covered by a third-party source.

☐ I, _____, (client / guardian name) understand the payment policy and the risks of not adhering to it.

_____ _____
Print Name of Client Date of Birth

_____ _____
Signature of Client, Guardian or Responsible Party Relationship to Client

_____ _____
Private Practitioner / Witness Date

Wright Therapy Group, LLC
& Therapy Consortium, Inc.
609 N. Main Street, Suite 106
Marion, SC 29571
Phone/Text: 843-289-5211
Fax 843-874-0850
info@WrightTherapyGroup.com

Patient Health Insurance Verification Form

Patient Name: _____ Date of Birth: _____

Primary Insurance: _____ Phone Number: _____
Member Name:_____ Employer:_____
Member ID #: _____
Group Number#: _____
Effective Date: _____ /_____ /_____

Secondary Insurance: _____ Phone Number: _____
Member Name:_____ Employer:_____
Member ID #: _____
Group Number#: _____
Effective Date: _____ /_____ /_____

Please provide front and back copies of most recent/up to date insurance card(s).

I do hereby attest that this information is true, accurate, and up to date and I understand that any falsification, omission, or concealment of information may subject me to liability. Furthermore, should *Wright Therapy Group, LLC* incur any charges, recoupment of payment, etc. due to my lack of providing accurate information, I take full responsibility and will be held financially liable for the fees *Wright Therapy Group, LLC* incurs.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____

Therapy Consortium Inc./Wright Therapy Group, LLC.

Phone/Text: 843-289-5211
Fax 843-874-0850
info@WrightTherapyGroup.com

Consent to Release/Obtain Information/Payment/ Treat
& Acknowledgment That You Have Received Our HIPAA Privacy Notice

I have been informed of the use and release of information collected through services received in regards to:

_____ . I request that copies of information in regards to my child be released to/from:
(patient's full name)

1. _____, 2. _____
(Child's Doctor) (Payer/Insurance-Medicaid/MCO and/or private)

3. _____, 4. _____
(Other Doctors) (School-if Appropriate/Daycare)

5. _____, 6. _____
(Babynet- if applicable/EI Group Name) (Other)

(Please read the following and then Initial Below)

____I request that payment of authorized Medicaid and third party payer's benefit be made to Therapy Consortium Inc./ Wright Therapy Group, LLC on my behalf for services furnished to me.

____I authorize Therapy Consortium Inc./Wright Therapy Group, LLC to release any medical information about me that may be needed to determine these benefits payable for related services.

____I understand that I will not be billed for any Medicaid services furnished to me which were billed to Medicaid during the time I had Medicaid coverage for those services.

____I understand that Therapy Consortium Inc./Wright Therapy Group, LLC is required by law to give me a copy of the privacy notice. I understand how my health info1mation may be used and shared.

____I understand that Therapy Consortium Inc./Wright Therapy Group, LLC is required by law to keep my health information safe. This information may include:

- Notes from your doctor, teacher, or other health care provider
- Your medical history & any treatment notes
- Test Results
- Insurance information

By signing this page you consent to have your child treated by **Therapy Consortium Inc./ Wright Therapy Group, LLC** for Speech Therapy Services and that you have been given a copy of our privacy notice.

_____ _____
Patient's Name Patient's Birthdate

_____ _____
Patient/Guardian Signature Date

_____ _____
Witness Date

THE WRIGHT THERAPY GROUP, LLC

Phone/Text 843.289.5211
Fax 843.874.0850
609 N. Main St., Ste. 106, Marion, SC 29571

www.WrightTherapyGroup.com
info@WrightThearpyGroup.com

Greetings,

Wright Therapy Group, LLC, Speech & Language Therapy Services (WTG) is committed to providing the highest quality of services to its clients and families. To meet the speech and language developmental needs of our clients, WTG services are provided by highly qualified speech-language pathologists, speech-language pathology assistants, and speech-language pathology student clinicians.

Speech-Language Pathologist (SLP): Has earned a master's degree in speech-language pathology, a Certificate of Clinical Competency (CCC) from the America Speech-Language-Hearing Association (ASHA), and is licensed by South Carolina Department of Labor & Licensing Regulation (SC LLR).

Speech-Language Pathology Assistant (SLPA): Has earned a bachelor's degree in speech-language pathology, is licensed by SC LLR, and works under the supervision of a CCC licensed speech-language pathologist.

Speech-Language Pathology Student Clinician (SLPSC): Has earned a bachelor's degree, is enrolled in an acccrediated master's degree program in speech-language pathology, and provides therapy services under the direct supervision of a CCC licensed speech-language pathologist.

Your consent grants our trained team of SLPAs and/or SLPSCs to screen, evaluate, and/or provide direct therapy services under the close supervision of a CCC licensed SLP. The SLP will ensure tailored, comprehensive, and effective services are provided to meet each client's individual needs. Your consent will also aid us in meeting the demands of the increasing number of clients that can benefit from speech and language therapy services. If you have any questions or concerns, please do not hesitate to contact us.

PERMISSION GRANTED: PLEASE CIRCLE YES OR NO

Speech-Language Pathology Assistant: YES NO

Speech-Language Pathology Student Clinician: YES NO

_____

Parent/Guardian/Responsible Party Signature Date

Wright Therapy Group, LLC

HIPAA - Your Privacy Rights

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.

Effective date: _____

Wright Therapy Group, LLC is required by law to keep your health information safe. This information may include:

- notes from your doctor, teacher, or other health care provider
- your medical history
- your test results
- treatment notes
- insurance information

A government rule, called the Health Insurance Portability and Accountability Act, or HIPAA, requires that you get a copy of this privacy notice. We will ask you to sign a paper saying that you have been given this notice.

Read and refer to this notice at any time to see how your health information can be used and who can see it.

How Your Health Information May Be Used or Shared

We may use or share your health information without your permission for the following reasons:

- **Treatment.** We may share information with doctors and other health care providers who care for you. For example, if your doctor orders speech therapy, we will share the results of our treatment with that doctor.
- **Payment.** We may use and share information about the treatment you receive with your insurance company or other payer to receive payment for services. This may include sharing important medical information. We may share information to:
  - get the insurance company's permission to start treatment
  - get permission for more treatment
  - get paid for the treatment you receive

- **Health Care Operations.** We may use and share your health information to run the clinic and be sure that all patients receive good care. For example, we may use your health information to:
  - see how well our services are working
  - see how well our staff is doing
  - see how we compare to other clinics
  - make our services better
  - help others study health care services

Your Health Information May Also Be Used or Shared Without Your Permission for:

- **Abuse and Neglect.** We may share your health information with government agencies when there is evidence of abuse, neglect, or domestic violence.
- **Appointment Reminders.** We will use your information to remind you of upcoming appointments. Reminders may be sent in the mail, by e-mail, or by phone call or voicemail message. If you do not wish to get reminders, please tell your speech-language pathologist.
- **As Required by Law.** We will share your information when we are told to do so by federal, state, or local law. We will also share information if we are asked by the police or courts.
- **Government Functions.** Your information may be shared for national security or military purposes. If you are a veteran, your information may be shared with the Office of Veteran's Affairs.
- **Information About a Person Who Has Died.** We may share information with the coroner, medical examiner, or a funeral director, as needed.
- **Marketing.** We may use your information to let you know of other services that might be of interest to you.
- **Public Health Risks.** We may report information to public health agencies as required by law. This may be done to help prevent disease, injury, or disability. It may also be done to report medical device safety issues to the Food and Drug Administration and to report diseases and infections.
- **Regulatory Oversight.** We may use or share your information with agencies overseeing health care. This may include sharing information for audits, licensure, and inspections.
- **Research**. We may share your health information with researchers to be included in their research project. Information will be shared only for projects that have been through a special approval process. These projects have rules to protect your privacy, too.
- **Threats to Health and Safety.** Your health information may be shared if we believe that it will prevent a threat to your health and safety or the health and safety of others.
- **Worker's Compensation.** We will share your information with Worker's Compensation if your case is being considered as a work-related injury or illness.

When Your Permission Is Needed to Use or Share Your Health Information

You must give us permission to use or share your health information for any situation that is not listed in this notice. You will be asked to sign a form, called an authorization, to allow us to use or share your information. You are allowed to take back this authorization, called revoking authorization, at any time. We will not be able to get back the information that we shared with your permission.

Your Privacy Rights

You have the right to:

- **Ask us not to share your information.** You can ask us not to use or share your information for treatment, payment, or health care operations. You can also ask us not to share information with people involved in your care, like family members or friends. You must ask for limits in writing. We must share information when required by law. We do not have to agree to what you ask.
- **Ask us to contact you privately.** You can ask us to contact you only in a certain way or at a certain place. For example, you may want us to call you but not to e-mail you. Or you may want us to call you at work and not at home. You must ask us in writing. We will do all we can to do what you ask.
- **Look at and copy your health information**. You have the right to see your health information and to get a copy of that information. You have a right to see treatment, medical, and billing information. You may not be able to see or copy information put together for a court case, certain lab results, and copyrighted materials, such as test protocols.
- **Ask for changes to your health information**. You can ask us to change information that you think is wrong. You can also ask that we add information that is missing. You must ask us in writing and give us a reason for the change. We do not have to make the change.
- **Get a report of how and when your information was used or shared.** You can ask us to tell you when your information was shared and who we shared it with. There are some rules about this:
    - You need to ask us in writing.
    - You must tell us the dates you are asking about and if you want a paper or electronic copy.
    - You may get information going back 6 years, but it cannot be for earlier than April 14, 2003. This is the date when the government privacy rules took effect.
- **Get a paper copy of this privacy notice.** You can get a paper copy of this notice at any time. You can get a copy even if you have already signed the form saying you have seen this notice.

- **File complaints.** You can file a complaint with us or with the government if you think that
  - your information was used or shared in a way that is not allowed
  - you were not allowed to look at or copy your information
  - any of your rights were denied

Who Is Covered by This Notice

The people who must follow the rules in this notice are:

- all speech-language pathologists working at **Wright Therapy Group, LLC**
- anyone who is allowed to add health information to your file, including students and other staff
- any volunteers who may help you while you are in this clinic

Changes to the Information in This Notice

We may change this notice at any time. Changes may apply to information we already have in your file and to any new information. Copies of the new notice will be available from our staff. The notice will have a date on the front page to tell you when it went into effect.

Complaints

You may file a complaint if you think we did something wrong with your information. You can complain to your regional office of the United States Office of Civil Rights. To find out more about filing complaints, go to www.hhs.gov ocr privacy hipaa complaints/index.html. All complaints must be in writing. You will not get in trouble for filing a complaint.

Contacts

If you have any questions about this notice or your privacy rights, please ask your speech-language pathologist.