Pediatric Speech-Language Therapy
“Always Cultivating Responses

Patient Intake Packet

Date: ____________ Patient Full Name: ___________________________________ DOB:________ M______F______

Parent/Caregiver name(s)____

Address: ____

____

Phone: _________________________ Work: __________________________ Cell: _____________________________

Primary Care Physician: ______________________________________ Phone:_______________ Fax:________________

Address: ____

____

Payment

(Check all payment sources available).

___Group Health Plan ___Individual Policy ___ Medicaid/CMO ___ Worker’s Compensation/Litigation

Please fill in below the information associated with the payment source that is checked above.

Responsible party

Name of insurance holder ____ Date of birth ___________

Address (street) ____ (apt./lot) _______________

City _______________________________________ State ________________ Zip code _______________

Phone (home) _______________________ Work ______________________ Cell ___________________

Employer ____ Phone ________________________

Primary insurance ______________________________________ Plan type/Name _______________________

ID number _____________________________ Group number ________________________

Secondary insurance _____________________ Yes/No ID number/Group number_____________________________

Is there any other Health Benefit Plan? Y___ N___ If your answer is yes, please let us know.

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Assignment of Benefits

My insurer (Medicaid, CMO's, insurance company, attorney, etc.) is hereby requested to pay directly to any monies due on my behalf. I understand that in Medicaid assigned benefits or other claims, ACR Speaking Dimensions, Inc agrees to accept the payment determination of the carrier as full payment and I am only responsible for the deductible, coinsurance, out of network costs and non-covered services on my claim. I agree to pay, ACR Speaking Dimensions, Inc. the deductible, coinsurance, out of network costs and non-covered services on my claim as soon as notified. I understand that I am responsible for all of the fees not covered by insurance, Medicaid, CMO's, etc., if it is determined that such coverage does not exist or has been terminated for any reason. I understand that I am responsible for staying up-to-date regarding my insurance coverage. I understand that I must inform ACR Speaking Dimensions, INC with any coverage or benefit changes immediately and cannot hold the provider responsible for any such changes. **Therapy services, although might be covered, are still the responsibility of guarantor.** Any claims to insurance company(s) are filed out of courtesy for the patient by the provider. The provider will make two attempts with insurance company to process the claim. If insurance continues to deny, patient/guarantor is responsible for payment of services in full and must contact insurance company. **I will provide my insurance card and identification with any updates each year/policy change.**

Name *(print)* ________________________________ Signature ____

Date ________________

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Patient Authorization to Evaluate and Treat

I authorize ACR Speaking Dimensions, INC. to give my child a speech and language evaluation and for my child to participate in speech/language therapy, if recommended. Therapy will be provided at the speech-language therapy client of ACR Speaking Dimensions, INC., a daycare, or private school as agreed upon by both parties involved.

Responsible Party ***(print)***: ________________________________

Parent/Guardian Signature:________________________________ Date:_________________

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Authorization to Release Information

Name of Child: ____ Date of Birth_____________

I hereby authorize ACR Speaking Dimensions, INC *to release all valuable speech-language, educational, psychological, medical* (other)________________________________ *information on my child in order to determine the most appropriate treatment program.*

Records are to be released to:
Name of institution/office/professional: _______________________________________
Address: ____
*Phone:*_________________________________ *Fax:* __________________________

I understand that the information contained in my or my child's medical/school records is confidential and will be released only upon my signature.

Signature of patient/parent/guardian ____ Date ___________________

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Child Case History Form

Child's Name ____ Date of Birth _____________ M______F______

Mother/Caregiver name:___________________________Occupation:_________________________ Cell:________________

Father/Caregiver name:____________________________Occupation:_________________________ Cell:________________

Reason for Referral

What concerns do you have about your child's communication skills?____

____

____

When was the communication difficulty first noticed?____

Has it changed since it was first noticed?___ How?____

____

Prenatal and Birth History:

Mother's general health during pregnancy (illnesses, accidents, medications, etc): _______________________________________

____

____

Length of pregnancy/labor:________________________ Delivery type:___________________________ Birth weight:________

Any complications at birth?____

Medical History:

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

Has your child had any serious injuries? If so, please explain. ____

Describe any major illnesses?____

How often does your child get ear infections? ____

Medications? ____ Allergies?______________________________ _______

Date/results of your child's last vision or hearing screening? ____

Developmental Milestones (at what age):

Babble______ First Word_______ Phrases (2 or more words)_______ Sit__________ Crawl__________ Stand__________

Walk________ Potty Trained________

Comments about development:____

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Family History

How many siblings? ___ Names and ages?____

____

Does anyone else in the family have the same speech/language difficulties?____________________

____

Do family members have difficulty understanding your child's communication exchanges?______________

Is your child aware of communication difficulties?____ If yes, how does he/she feel about it?______________

____

What language(s) are spoken in the home?____

What system of consequences/rewards do you have when your child misbehaves or does a good job? (please explain)______________

____

____

What are your child's interests?____

____

What does your family enjoy doing together?______________________________________

Prior Therapy Services

Does your child receive any other therapy at this time?

Has your child received ST, OT, PT, music etc. therapy in the past?

If so, explain the purpose of therapy.____

Does your child have an Individualized Education Plan (IEP)? Yes/No If yes, a copy needs to be provided to proceed with an evaluation and therapy.

Does your child have an Individualized Service Plan (ISP) ? If yes, please provide us with a copy.

Education

Academic Strengths? ____

Academic Challenges? ____

Any Grades Repeated? ____

Behavioral Concerns? ____

Social/Emotional Concerns? ____

Sensory Concerns (picky eater, dislikes or likes certain textures/sounds/touch, clumsy or likes to fall, etc)______________

____

Person completing form (print):_________________________________ Date:_______________

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Acknowledgement That You Have Received Our HIPAA Privacy Notice

ACR Speaking Dimensions, INC is required by law to keep your health information safe.

This information may include:

- Notes from your doctor, teacher, or other healthcare provider
- Medical history
- Test results
- Treatment notes
- Insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information may be used and shared.

I acknowledge that I have received a copy of HIPAA Notice of Privacy Practices that fully explains the uses and disclosures they will make with respect to my individually identifiable health information.

I have had the opportunity to read the notice and to have any questions regarding the notice answered to my satisfaction.

I understand that ACR Speaking Dimensions, INC cannot disclose my health information other than as specified in the notice.

I understand that ACR Speaking Dimensions, INC reserves the right to change the notice and the practices detailed therein and if it does, a revised copy of the notice will be sent to the email address I have provided.

Print Name of Client:_________________________________ Client Date of Birth:_______

Name of Legal Representative____

Signature of Client or Legal Representative ____

Relationship to Client:______________________________