Little Angels Center – Adult Case History Form

Name: _____ DOB: _____ Age: _____ Today's Date: _____

Home address: _____

Phone number (h) _____ (c) _____ (w) _____

Do you have difficulty with your vision and/or hearing? If yes, please describe: _____

_____

Highest level of Education: _____ Profession: _____

Employer: _____

Primary Care Physician: _____ Phone: _____ Fax: _____

Primary Care Physician's Address:

_____

Past Medical History(include any recent surgeries/hospitalizations)

_____

_____

_____

_____

Allergies:

_____

What are your current concerns regarding your speech, language, swallowing or motor skills?

_____

_____

What do you think caused the above difficulties?

_____

_____

_____

When did you first notice the problem? Has the problem changed (worsened/resolved)?

_____

_____

_____

_____

Swallowing Skills: Check off any areas of difficulty

___ chewing food ____ Drooling ____ Moving food to the back of the mouth

___ managing liquids ____ Increased meal times ____ Clearing food/liquid from the mouth

___ coughing ____ holding cup/utensils ____ watery eyes when eating/drinking

___ choking ____ Other

_____

Are currently on a modified food and/or liquid diet? If yes, please explain:

_____

_____

_____

Family/Social History:

Indicate marital status: Single ____ Widowed _____ Divorced _____ Married _____

Who do you live with? _____

Will you/your family member attend with an aide present? _____ yes ____ no If yes, may the therapist relay information regarding therapy progress and recommendations to the aide? ____ yes ____ no

**It is imperative that the aide remain in the building while the participant is in therapy.*

Is there any family history of speech, language, hearing, medical or mental health issues? If yes, describe:

_____

_____

_____

List hobbies/interests:

_____

_____

Please provide any additional information that may be helpful to the evaluation/treatment process:

_____

_____

_____

_____

Therapy Contract

Patient Therapy Contract: I/We will be responsible for practicing regularly, which may mean up to three times per day and for as long as the therapist deems it necessary. In order for me/my child/my adult to master techniques and skills taught during therapy, I/we must follow the rules and practice schedule outlined by my therapist. Furthermore, it will be my/our responsibility to schedule any and all re-evaluations when informed by my therapist. My/my child's/my adult's progress is directly related to the joint efforts of the therapist and me/my family. _____ Initial here

Patient Video/Photograph Authorization: As part of the evaluation and /or therapy process it is sometimes beneficial for a therapist to videotape/photograph you/your child/your adult during the evaluation/therapy session. This allows us to look back and review you/your child's/your adult's difficulties and progress as

therapy continues. In doing so, we are able to draw more accurate conclusions and provide appropriate treatment plans and goals.

By signing below, you will be giving authorization to the therapists of our centers to photograph/videotape you/your child/your adult as the therapist sees fit. These photographs/videos will *solely be used for the purpose of assessing you/your child's/your adult's difficulties, progress and for devising appropriate treatment plans. I understand that any photos or videos taken will be solely for therapy purposes only.*

_____ I agree for myself/ my child/ my adult to be photographed for therapy only purposes

_____ I agree for myself/ my child/ my adult to be photographed and shared on social media to promote therapy techniques

_____ I do not want to be photographed for any purpose.

HIPPA Compliant Authorization for Release of Protected Information

I, _____ authorize the release of my protected health information, or the information for _____ (adult/minor) as described herein. I understand that authorizing the disclosure of this information is voluntary.

I understand that, if the person(s) or organization (s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organizations may not be protected by those laws.

Please list any and all people, organizations agencies or designated recipients who will be attending therapy with the patient, so that information regarding patient progress, goals and needs, may be shared with this person.

I authorize the following person(s) and/or organization(s) to receive my protected health information. Information regarding the patient goals, and needs, may be discussed with this person.

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

I understand I have the rights to revoke this authorization in writing at any time. I understand

that revocation will not apply to any information that has already been released in response to this authorization.

Date: _____ Name of person who you would like revoked _____

_____

Signature of Parent or Legal Representative

No information including evaluations, daily log notes and/or progress notes concerning the child/patient will be released unless this form is signed by the parent/patient/legal guardian.

I authorize Little angels Center Inc.

By signing on the lines below, I acknowledge that I have received and review the "Notice of Privacy Practices". If you have any questions, you can contact the Sue Coletta at 631-363-5794.

_____ _____

Signature of Patient, Parent or Legal Representative Date

The confidentiality of your adult/ child's information is important to us. Please indicate the type of communication that you prefer after each session. Please understand this communication will be brief and if you would like more information you may set up a phone call or meeting with your adult/ child's therapist.

____ Please provide a brief description of my adult/ child's session in the waiting room

____ Please provide ALL communication about my adult/child's session in the therapy room.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you may access this information.

1. **Uses and Disclosures:** We will use your protected health information (PHI) for the purposes of treatment, payment and health care operations.

Treatment includes the disclosure of health information to other providers who have referred you for services or are involved in your care. This may include doctors, nurses, technicians and other speech pathologists. For example, we may feel that a stroke patient we treat would benefit from an evaluation by a physical therapist to address their physical limitations. The health information we share with the physical therapist would be considered a treatment related disclosure.

Payment includes the disclosure of health information to your insurance company, including Medicare and Medicaid, so payments can be obtained for services rendered. Your insurance company may make a request to review your medical record(s) to determine that your care was necessary.

Health Care Operations includes the utilization of your records to monitor the quality of care given at our facility or for business planning activities.

Other Special Uses: Our practice may use PHI to send you an appointment reminder, to inform you of our health related products and services, or to request a contribution to charitable activities.

Uses and Disclosures required by Law: The federal health information privacy regulations permit or require us to use or disclose PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object; we may disclose your PHI in an emergency

situation, for research purposes (if we are provided with specific assurances that your privacy will be protected) or if we are required to do so by law (i.e. by court or subpoena). Disclosure to health oversite agencies are sometimes required by law to report disease or adverse drug reactions. If you are in the Armed Forces, we may release health information about you if deemed necessary by appropriate military command authorities. We may also release information about you for worker's compensation or other similar programs that provide benefits for work-related injury or illness. Your authorization is required before your PHI may be used or disclosed by us for other purposes.

2. My Privacy Rights:

Restrictions: you have the right to request a restriction on how your PHI is used; however; we are not required to agree with your request. If we do agree, we strongly abide by the request.

Confidential Communications: You have the right to submit a written request for confidential communication from us at a location of your choosing.

Access to PHI: you have the right to submit a written request for a copy of your medical records. We may charge a fee to cover the cost of copying and mailing.

Amendments: you have the right to submit a written request for an amendment to be made for your PHI if you disagree with its information about you and state why you believe it must be amended. If we disagree with you, we are not required to make the amendment. We may not amend any parts of your medical record we did not create.

Combined Rehabilitative Services

Some insurance companies will group rehabilitative services such as physical therapy, occupational therapy and speech therapy together while handling an individual's file. Therefore, it is important that Little Angels Center is aware of your status pertaining to other rehabilitative services as they will impact your speech therapy coverage.

Are you currently receiving Occupational Therapy Services? Yes____ No ____ If yes, how often? _____

Are you currently receiving Physical Therapy Services? Yes ____ No ____ If yes, how often? _____

Are you currently receiving Speech Language Therapy Services? Yes _____ No ____ If yes, how often? _____

- **If at any time you do seek occupational or physical therapy services during your treatment at Little Angels Center, you must inform our billing department to ensure continued coverage on a per visit basis by your insurance provider.**

Payment is expected at the time of service unless other arrangements are made in advance of your visit. I authorize payment of insurance benefits directly to the physical for medical services provided. I further authorize the release of medical information necessary to process this claim. In the event that my insurance denies payment of a claim, either in whole or n part, I understand I am responsible for the payment in full.

I have ensured the necessary referrals for services have been obtained. If not, I understand I responsible for all charges. By signing below, I am verifying that the above information provided is true. I have read, understand and agree to all terms and conditions listed above.

Furthermore, I understand that by signing below, I will be considered the guarantor on file. Therefore, any/all fees incurred during the time you/the patient seek therapy will be your responsibility. If you are not the guarantor, then you must have this signed and returned with the guarantor's information during subsequent visits in our office(s). If the guarantor doe3s not sign, the responsibility of the fees will continue to be the responsibility of the signee.

Patient's Name (Print): _____ Date:_____

Signature of Guarantor: _____ Relationship to Patient: _____

Insurance Policy Holder: _____

If you have an aide/family member that is responsible for you, they must wait in the waiting room. They are not allowed to leave the building as they are responsible for your safety while you are in the building.

We are not responsible for injury or lost property if the patient is left alone on the premises.

Responsible Party (print): _____

Signature of responsible Party: _____

PATIENT ELIGIBILITY WAIVER & FINANCIAL RESPONSIBILITY FORM

The purpose of this form is to help our patients understand about medical insurance, eligibility, coverage and our office policy.

Please review and agree that:

- We render our services on the basis that insurance companies may or may not pay for all, or a portion of our charges.
- Authorizations for treatment from your insurance company/doctor do not guarantee full payment for the service.
- Not all insurance companies/third party payers pay for all services, each policy has its own particular stipulations regarding covered services, or amount of coverage.
- I understand certain diagnoses may not be covered by my insurance company; developmental, intellectual, behavioral and/or other findings. If my initial evaluation is denied for that reason, I would be responsible for that payment. At that time, if I choose to continue with therapy, payment options will be explained to me.
- All insurance companies state that verification of coverage is not a guarantee of coverage or payment. Actual benefits are determined by your insurance company after a claim is received.
- Patients are personally responsible for knowing and understanding their own insurance policy, eligibility and coverage.
- If your benefits are combined with other therapies or rehabilitation services (including, but not limited to: physical therapy, occupational therapy, post cochlear rehab, cardiac/pulmonary rehab, chiropractic care, cognitive rehab, vision therapy, etc) you will need to keep track of your visits. We are unable to see your count of visits from other facilities. If visits are exceeded, you will be responsible for payment.
- Patients are responsible for payment of deductibles, co-insurance and/or copayments, where applied. Copayments will be collected at the time of visit and may change based on procedures.

- Patients are financially responsible for any non-covered services.
- I am aware that my insurance company may send me payments or Explanations of Benefits (EOBs) for services rendered. I agree to sign the check over and include a copy of the EOB when sending it to my provider. If I fail to do this, I will be responsible for the entire fee for all services rendered, plus any additional collection fees and legal costs in connection with collecting this debt.
- Any appointment missed or not canceled more than 24 hours in advance will incur a $40.00 charge.
- Returned checks are subject to a $35.00 fee.
- Changes in your insurance coverage must be reported to our staff promptly to avoid financial responsibility.

My benefits have been explained to me. I understand this is not a guarantee of payment and know that if my claim is denied, I am responsible for payment.

The patient or patient's legal representative understands his/her health insurance benefits and coverage. In the event of ineligibility for coverage of plan benefits, as well as non-covered services, he/she understands and agrees to be fully financially responsible for payment.

_____ _____

Patient Name Date of Birth

_____ _____

Signature of Patient or Guardian Date

List of Current Medications Date updated: _____

List all tablets, patches, drops, ointments, injections etc. Include prescription, over the counter, herbal, vitamin and diet supplemental products. Also list any medicine you take only on occasion

Medication Name	Dose	How often do you take the medication	Reason for taking the medication	Date started	Prescriber