Little Angels Center

PEDIATRIC CASE HISTORY FORM

Date: _____

Child's Name: _____ Date of Birth: _____ Male: _____ Female: _____

Home Address: _____

Home Phone Number: _____ Cell phone Number_____

Form completed by: Mother: _____ Father: _____ Guardian: _____ Caregiver: _____ Other: _____

Family Information:

Parent/Guardian: _____ DOB: _____

Occupation/Employer: _____

Address (if different than above): _____

Cell phone: _____ Work: _____

Parent/Guardian: _____ DOB: _____

Occupation/Employer: _____

Address (if different than above): _____

Cell phone: _____ Work: _____

Insurance Carrier: _____

Policy Holder Name: _____ Date of Birth: _____

Secondary Insurance Carrier: _____

Policy Holder Name: _____ Date of Birth: _____

Pediatrician Name: _____ Phone Number: _____

Referred by: _____ Phone Number: _____

Statement of Problem:

Does your child have a formal diagnosis? Yes___ No____ If yes, what is the diagnosis?

_____

_____

In your own words, describe your current concerns regarding your child's ability to communicate. Indicate when the problem was first noticed and by who. Are there any skills the child had learned previously, but can no longer use?

_____
_____
_____
_____

Have any family members had any speech, language, hearing problems, or learning difficulties?

Yes__ No__ If yes, state who and describe:

_____

_____

Has the child's hearing been tested? Yes____ No____ If yes, please bring a copy of the hearing test results to your appointment.

Family Background:

Name of Others Living with Child	Relationship to Child	Date of Birth

What languages are spoken in the home? _____

Primary Language spoken at home: _____

Medical History:

Describe prenatal history? Were there any complications/problems during the pregnancy?

_____
_____
_____

Describe perinatal history (was the pregnancy full term, were there complications during the delivery, APGAR scores, birth weight)

_____

_____
_____

Describe your child's medical history (illness, surgeries, accidents, hospitalizations)

_____

_____
_____
_____

Current list of medications:

_____

_____

Any allergic reaction to any medications?

_____

_____

Describe the child's feeding skills? (chooses a variety of foods; textures, difficulty swallowing)

_____

_____

_____

Does your child use a pacifier? _____ Drink from a bottle_____ A straw cup_____ an open cup_____

Has your child had any of the following evaluations or assessments? If yes please bring the results to your evaluation.

___ hearing ___ speech and language ___ psychological ___ physical therapy

___ neurological ___ occupational therapy ___ developmental ___ vision

Developmental History:

Provide the approximate age at which the child acquired the following skills. If you can't remember the age, check the box that best describes when he/she acquired the skill as compared to his/her peers.

Activity	Age	Earlier than Peers	Same Time as Peers	Later than Peers
Sit				
Crawl				
Roll Over				
Walk				
Walk up/downstairs				
Feed Self				
Dress Self				
Use Toilet				

How would you describe your child's overall motor development (running, skipping, grasping crayons/pencils) as compared to his/her same age peers?

_____

_____

_____

Speech and Language History:

Please provide the approximate age at which the child acquired the following skills. If you can't remember the age, check the box that best describes when he/she acquired the skills as compared to his/her peers.

Activity	Age	Earlier than Peers	Same Time as Peers	Later than Peers
Babbling				
Use First Words				
Put 2-3 Words Together				

Name of Person Completing this form: _____ Relationship: _____

Signature of Person Completing this form: _____ Date: _____

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 _____ (minor child) 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 here 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.

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 child’s information is important to us. Please indicate the type of communication that your 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 child’s therapist.

____ Please provide a brief description of my child’s session in the waiting room

____ Please provide ALL communication about my 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.

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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: _____