

SPEECH & HEARING

C E N T E R
SAVANNAH

Child Case History Form (Speech and Hearing)

Date: _____

Child's Name _____ Birth date _____ Age _____

Gender: Male / Female Race: _____ (United Way Statistics)

Parents _____

Brothers/Sisters (names & ages) _____

Address _____

Street/P.O. Box _____ City _____ State _____ Zip Code _____

Home Phone _____ Work _____ Emergency _____

Child's School _____ Teacher _____ Grade _____

Parent's Occupation: Father _____ Mother _____

Referred By: _____

Describe Problem: _____

How did you hear about our services? _____

May we contact you via email? Yes ___ No ___ If yes, email address: _____

Pregnancy and Birth Information

Any unusual illness during pregnancy? _____
(measles, Rh factor, diabetes, high blood pressure, toxemia, etc.)

Was the mother given medication during pregnancy? _____

Length of pregnancy? _____ Months Child's birth weight: _____ lbs _____ oz

Circle any of the following which apply:

- | | | | |
|--------------|----------------|-------------------|-------------|
| breach birth | incubator used | instruments used | oxygen |
| C-section | discoloration | trouble breathing | antibiotics |

Developmental Information List the age at which the child achieved the following skills:

sat alone _____ crawled _____ walked alone _____

toilet trained _____ dressed self _____ fed self _____

Child's physical development has been: _____ fast _____ slow _____ normal

Which hand does the child prefer to use? _____

Medical Information Circle the illnesses or conditions the child has had: measles

- | | | | | |
|-----------|----------------|-------------------|-----------------------|----------------------|
| mumps | high fevers | chicken pox | coordination problems | dizziness |
| allergies | meningitis | eye problems | swallowing difficulty | cerebral palsy |
| flu | frequent colds | seizures | recurrent headaches | Down's syndrome |
| surgery | tonsillitis | serious accidents | mental retardation | respiratory problems |

Has the child received any of the following services?

- | | | |
|-------------------------|--------------------------|-------------------------------|
| _____ speech evaluation | _____ speech therapy | _____ occupational therapy |
| _____ special education | _____ physical therapy | _____ psychological testing |
| _____ academic tutoring | _____ genetic evaluation | _____ neurological evaluation |

Where? From whom? _____

Other Services: _____

Describes any serious illness or accident: _____

List the name of any medications the child receives on a regular basis:

List all doctors and addresses:

Hearing Information

1. Do you feel that the child has a hearing loss? If yes, when and how was it noticed? _____
2. History of ear infections? If yes, how many and when was the last one? _____
3. What treatment or testing has child received regarding ears? _____
4. Do any family members have hearing problems? If yes, who: _____
5. Has the child ever been exposed to loud noise or explosion? _____
6. Does the child: complain about fullness or noises in the ear? _____
become confused with where sound is coming from? _____
watch the speaker's face closely for cues? _____
7. Does the child respond to the following: (check all that apply)
____ his/her name ____ loud noises ____ soft noises ____ verbal commands ____ vibrations

Speech and Language Information

1. Did the child smile and cry appropriately as an infant? _____
2. At what age did the child: babble _____ use words _____ use phrases _____
3. Do any family members have speech problems? If yes, describe: _____
4. Is the child aware of his/her communication problem? _____
5. Do you think the child is behind in other areas? If yes, describe: _____
6. How do you communicate with the child? _____
7. Can the child follow simple verbal instructions? _____
8. How does the child make his/her needs known? _____
9. Circle any of the following that apply to the child: talks too rapidly talks too slowly
leaves out words poor comprehension use gestures rather than speech reverses word order
talks very little repeats or hesitates pronounces sounds incorrectly use incorrect grammar

Behavioral Information Circle any of the following that apply to the child's behavior:

- | | | | |
|--------------|-------------------|----------------------|---------------------------|
| hyperactive | tires easily | behavioral problems | prefers to play alone |
| underactive | slow learner | demands attention | confused in noisy places |
| impulsive | underachiever | easily distractible | sensitive to loud noises |
| daydreams | lacks confidence | talks excessively | says inappropriate things |
| withdrawn | easily frustrated | short attention span | under stress at home |
| cries easily | lacks motivation | nervous or sensitive | easily managed at home |

Educational Information

1. Has the child ever repeated a grade? _____ If so, what grade and why? _____
2. Has the child ever received any special help at school? _____ Please describe: _____
3. Does the child like school? _____
4. What are his/her best subjects? _____
5. What subjects are difficult for the child? _____
6. Has the child had a behavioral problem at school? _____ If so, describe: _____
7. Have teachers requested that hearing, vision, or speech be tested? _____
8. Is there a classroom problem with attention or following directions? _____
9. Is there a history of learning problems in the family? _____
10. Other educational information: _____

Additional Comments : _____

Your signature here grants permission to treat: _____

SPEECH & HEARING CENTER SAVANNAH

1206 East 66th Street, Savannah, GA 31404 ● Phone (912) 355-4601 ● Fax (912) 355-7935

INSURANCE / PAYOR INFORMATION

Patient's name as appears on policy: _____

Patient's Date of Birth: _____ Sex: M/F

Contact (if child): _____ phone home: _____

Hours can be reached at home - _____ phone work/cell: _____

Responsible party/bill to: _____

PRIMARY INSURANCE/Medicare

COPAY: \$ _____ **Insurance Referral Number:** _____

Insured/Policyholder's Name: _____
(who has the insurance)

Insured's Address: _____
(if different from the client)

Date of Birth (Policyholder's): _____ Insurance Company: _____

Member ID Number: _____ Employer: _____
(need the individual's identification number to file)

Relationship to Patient: _____ Date Coverage Began: _____

SECONDARY INSURANCE

Insured/Policyholder's Name: _____
(who has the insurance)

Insured's Address: _____
(if different from the client)

Date of Birth (Policyholder's): _____ Insurance Company: _____

Member ID Number: _____ Employer: _____
(need the individual's identification number to file)

Relationship to Patient: _____ Date Coverage Began: _____

MEDICAID or PEACHCARE

Name as it appears on the card:

Last: _____ First: _____ Middle Initial: _____

Recipient ID Number: _____

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INSURANCE / PAYOR INFORMATION (Continued)

Please understand that the primary goal of the Center is to provide service to the public. We attempt to work with our clients regarding obligations for services whether payment may be through insurance, private pay, co-payments or other arrangements.

If payment is not received from an insurance company within 3 months from the date billed or if a denial is received from an insurance company, we will be required to call upon you for payment. Should you choose to appeal the denial and win, you will be reimbursed by the Center any money owed to you. A finance charge of 1% will accrue if payment is not received by the Center within 30 days of the date you are billed.

ASSIGNMENT OF BENEFITS

I hereby authorize payment by my insurance carrier of the benefits, otherwise payable to me, to be made directly to **Savannah Speech and Hearing Center** for their services.

I certify that the information given by me in applying for payment is correct. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for services to **Savannah Speech and Hearing Center**.

I authorize **Savannah Speech and Hearing Center** to release to all insurance companies and/or compensation carriers only such diagnostic, therapeutic, and financial information as may be necessary to determine benefits entitled and to process payment claims for health service that will be provided.

The insurance information given is an attempt to collect a debt. Any information obtained will be used for that purpose.

I understand and agree that I am financially responsible for charges not covered by assignment.

Date

Responsible Party or Patient

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Please Read Carefully and Initial

NAME: _____

_____ **CONSENT TO TREAT**

I give consent for myself and/or family member to receive the necessary evaluation and/or treatment by Savannah Speech and Hearing Center.

_____ **RELEASE/REQUEST**

Permission is given to Savannah Speech and Hearing Center to release and/or request information when necessary for the records of the above named individual.

_____ **PAYMENT RESPONSIBILITY**

All professional services rendered are charged to the client. Necessary insurance information will be filed for the client. However, the client is ultimately responsible for payment.

_____ **INSURANCE AUTHORIZATION/ASSIGNMENT**

I allow my insurance company to be billed and I request that payment of authorized benefits be made directly to Savannah Speech and Hearing Center for any services furnished to me by that provider. I authorize the release of any information to my insurance company required in the course of treatment that may be used to determine benefits payable under my insurance plan.

_____ **HEARING AIDS**

My insurance policy does not include a hearing aid benefit. Please do not bill my insurance company for hearing aids.

_____ **CONTACT INFORMATION**

I give my consent to leave messages on my voice mail.

I prefer to be contacted at the following number(s).

- _____ Work _____
- _____ Home _____
- _____ Cell _____
- _____ Other _____

Signature

Date

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AUTHORIZATION FORM Use and Disclosure of Protected Health Information

Client's Name _____ DOB _____

I authorize **Savannah Speech and Hearing Center** to use or disclose the above named client's protected health information.

1. Persons or groups authorized to receive this information:

2. Description of the information to be used or disclosed:

3. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations or other applicable state or federal laws.

4. I understand that I may revoke this authorization in writing at any time except to the extent that the action on this authorization has not already occurred.

5. Unless otherwise revoked, this authorization will expire one year from the date of signature or less than a year as indicated: _____

Client (or Representative) Signature

Date

Name of Personal Representative (Please Print)

Relationship to Client

I have received a copy of the Savannah Speech and Hearing Center's Privacy Practices Notice. _____(INITIALS)

Client records are kept for a period of eight (8) years and then destroyed if there has been no activity within that period of time.