SAVANNAH SPEECH & HEARING CENTER

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Child Case History Form (Occupational Therapy)

Child's Name _____ DOB: _____ Age _____

Gender: _____ Race: _____ (United Way Statistics We Must Report)

Parent(s)/Caregiver(s) Name(s): _____

Brothers/Sisters (names & ages) _____

Address _____

Street/P.O. Box City State Zip Code

Home # _____ Work # _____ Cell # _____

Other # _____ Emergency # _____ (name) _____

Email address: _____

May we contact you via **US Mail** if the need arises? Yes☐ No☐ This is my **preferred** method.☐
May we contact you via **email** if the need arises? Yes☐ No☐ This is my **preferred** method.☐
May we communicate with you regarding your child via **text**? Yes☐ No☐ This is my **preferred** method.☐

Child's School _____ Teacher _____ Grade _____

Parent(s)/Caregiver(s) Occupation(s): _____

Physician who referred you here: _____

DESCRIBE REASON FOR THIS APPOINTMENT: _____

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:

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

Your child's current weight: _____ height: _____ Immunizations up to date? ____ Yes ____ No-explain _____

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:

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

--- CONTINUED ON BACK OF PAGE---

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? _____

Is your child currently enrolled in Babies Can't Wait (BCW)? □ No □ Yes If Yes, which county?

_____

Other Services: _____

Describes any serious illness or accident: _____

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

_____

_____

List all doctors:

_____

_____

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

Vision Tested? No □ Yes □ If Yes, date of last vision test & results _____

EQUIPMENT (Check all that your child has):

__ splint ___ braces ___walker ___cane ___bathchair ___prone stander ___ glasses ___wheelchair
___ TLSO
___ adaptive seating ___hearing aid ___
other:_____
_____

FEEDING

Check any of the following that you have observed:

___ putting too much food in mouth at one time
___ food falling out of mouth
___ difficulty chewing meats
___ coughing or choking on certain foods (list what foods) _____
___ picky eater
___ unable to drink without spilling
___ food aversion/refusal
___ history of aspiration
(date of most recent swallow study _____)

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: _____

_____

Signature for permission to treat: _____ **Date:** _____

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Name:_____

INITIAL

_____ **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.

_____ **MEDICAL RECORD DISPOSAL**
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. I understand and acknowledge this.

_____ **SPEECH THERAPY TEXT REMINDERS** *SPEECH CLIENTS ONLY*
I give my consent to receive weekly SPEECH THERAPY appointment reminders via text message.

_____ _____
Signature of Patient or Responsible Party **Today's Date**

_____
Please Print your Name

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AUTHORIZATION FORM

Use and Disclosure of Protected Health Information

Patient Name:_____ **DOB:** _____

I authorize Savannah Speech and Hearing Center to use or disclose the above-named client's protected health information to the following listed people ONLY:

Doctors, Family members, Therapists, Schools, ETC. authorized to receive this information: ***YOU MUST LIST THE SPECIFIC NAMES OF EACH***

1. Physician that referred:_____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

1. 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.
2. 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.
3. This authorization will expire **ONE YEAR** from the date of signature. At this point, you will be required to update this form.

_____ _____

Patient (or Patient's Representative's) Signature **Date**

_____

Please Print Name

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SPEECH & HEARING CENTER SAVANNAH

Name: _____ DOB: _____

ATTENDANCE AND HOMEWORK POLICY

****SAFETY FIRST:** Please plan to stay at the center during your child's appointments. We do **NOT** have medical or babysitting staff available. We do **NOT** assist children in the restroom****

ATTENDANCE POLICY: Savannah Speech and Hearing Center clients are expected to attend at least 75% of scheduled appointments. Although illnesses and other scheduling conflicts sometimes arise, regular attendance is required if we are to expect progress in therapy. The Center's therapists are expected to remove poor attenders from their schedules and offer therapy to other clients who are waiting for services.

CLIENT AGREES: I understand that my/my child's name **will be removed** from the therapist's schedule if regular attendance is not maintained, according to Center policy. I understand I am welcome to request a new therapy schedule when regular attendance is more likely.

Signature:_____ Date: _____

HOMEWORK POLICY: Home assignments and suggestions are made for the benefit of the client's progress. It is likely progress will be more rapid if home follow-through is consistent.

CLIENT AGREES: I agree to complete home assignments on a regular basis to support therapy progress.

Signature:_____ Date: _____

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Patient Name: _____ **Date of Birth:** _____ **Gender:** _____

Please Circle Which Insurance Patient has: Amerigroup Peach State SSI Medicaid Care Source

ID#: _____

If Amerigroup, Care Source or Wellcare, please also provide Medicaid ID#: _____

●●

Primary Insurance Information

Policy Holder Name: _____ Date of Birth: _____

Insurance Company Name: _____ Employer: _____

Member ID # or (Social Security Number if Medicare/Tricare): _____

Member Service /Customer Service Phone #: _____ Group #: _____

Policy Holder Relation to Patient _____

●●

Secondary Insurance Information

Policy Holder Name: _____ Date of Birth: _____

Insurance Company Name: _____ Employer: _____

Member ID # or (Social Security Number if Medicare/Tricare): _____

Member Service /Customer Service Phone #: _____ Group #: _____

Policy Holder Relation to Patient _____

FLIP OVER FOR REQUIRED SIGNATURE TO TREAT

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

If payment is not received from your insurance company within 3 months from the date billed, or if a denial is received from your insurance company, we will be required to call upon you for total payment owed. Should you choose to appeal the denial and win, you will be reimbursed by Savannah Speech & Hearing 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 & 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 & Hearing Center**.

I authorize **Savannah Speech & Hearing Center** to release to all the 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 all charges *not covered* by assignment.

_____ _____

Responsible Party or Patient Signature **Date**

_____

Please PRINT the Above Name