SAVANNAH SPEECH & HEARING CENTER

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Pediatric Case History Form for SPEECH-LANGUAGE PATHOLOGY

Child's Name: _____ DOB: _____ Age _____

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

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

Relationship to Child: Parent☐ Grandparent☐ Legal Guardian☐ Other_____

Brother(s)/Sister(s)/name(s) & age(s): _____

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.☐

Parent's/Caregiver's Occupation: Father(s) _____ Mother(s) _____

Physician who referred you here: _____

Languages spoken in the home: _____

DESCRIBE CONCERNS YOU HAVE WITH YOUR CHILD'S DEVELOPMENT: _____

_____

_____

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
Check any of the following which apply:

breech 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 Check the illnesses or conditions the child has had. measles __

mumps __	high fevers __	chicken pox __	coordination problems __	serious accidents __
allergies __	meningitis __	eye problems__	eating/drinking difficulties __	cerebral palsy__
frequent colds/flu __	snoring __	seizures __	recurrent headaches __	Down's syndrome__
tonsillitis __	surgery __	dizziness __	intellectual disability __	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? _____

Other Services: _____

Describe any serious illness or accident: _____

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

_____

List all doctors:

_____

_____

Hearing Information

1. Did your child pass the newborn hearing screening? _____
2. Do you feel that the child has a hearing loss? If yes, when and how was it noticed? _____
   _____
3. History of ear infections? If yes, how many and when was the last one? _____
4. What treatment or testing has child received regarding ears? _____
5. Do any family members have hearing problems? If yes, who: _____
6. Has the child ever been exposed to loud noise or explosion? _____
7. 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? _____
8. Does the child respond to the following: (check all that apply)
   _____ their 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
   poor comprehension leaves out words use gestures rather than speech reverses word order
   talks very little repeats or hesitates pronounces sounds incorrectly use incorrect grammar

Behavioral Information Check 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 __

--- CONTINUED ON BACK OF PAGE---

Educational Information

Child's School _____ Teacher _____ Grade _____

Classroom type: Regular _____ Inclusion _____ Self-Contained _____ Other _____

1. Has the child ever repeated a grade? _____ If so, what grade and why?
   _____
2. Does your child have an IEP or 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