SAVANNAH
SPEECH & HEARING
CENTER

Sound Principles. *Speak Volumes.*™

Child Case History Form (Physical 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 Occupation: Father ________________ Mother ____________________

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 <u>**age**</u> 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	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? ____

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

Has your child ever had his Hearing Tested? ☐ No ☐ Yes

Other Services: ____

Describes any serious illness or accident: ____

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

List all doctors:
____
____

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:____
____

Additional Comments: ____
____

Signature for permission to treat: ____**Date:** _______________

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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

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: ______________________

Patient Name: ______________________________________ **Date of Birth:** _____________ **Gender:** _______

Please Circle Which Insurance Patient has: Amerigroup Wellcare 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

Savannah Speech and
Hearing Center
5414 Skidaway Road
Savannah
Georgia, 31406

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH AND MEDICAL INFORMATION IS IMPORTANT TO US.

OUR RESPONSIBILITIES

We at Savannah Speech and Hearing Center understand that medical information about you and your health is personal. Applicable federal and state law requires us to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect This Notice takes effect 07/27/23, and will remain in effect until we replace it. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose health information about you for treatment, payment, and healthcare operations. For example:

To Treat You: We can use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Billing and Payment For Services: We can use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We can use and disclose your health information in connection with our healthcare operations which include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time; your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you as described in the Patient Rights section of this Notice We may disclose your health information to a family member, friend or another person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for

your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing purposes without your written permission.

Required by Law: We may use or disclose your health information when we are required to do so by state or federal law, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, text messages or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies, mailing, and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end

of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Records Transfer: If a healthcare practice where your health information records reside is sold or merges with another practice or organization, your records will be transferred to the new owner. However, you may request that copies of your health information be transferred to another practice.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Officer: Sheana Richardson
Telephone: 9123554601
E-mail: SRichardson@speechandhearingsav.org
Address: 5414 Skidaway Road
Zip Code: 31406
State: Georgia
City: Savannah

SAVANNAH

SPEECH & HEARING

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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.

________ **NOTICE OF PRIVACY PRACTICES**

I acknowledge that I received a copy of the Notice of Privacy Practices for the Savannah Speech and Hearing Center. Either a physical copy or digital copy was supplied to me.

________ **THERAPY TEXT REMINDERS**

I give my consent to receive weekly appointment reminders via text message.

________________________________ ________________

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

____

Please Print your Name