Speech Matters, LLC

2328 Hancock Bridge Pkwy

#101

Cape Coral, FL 33990

Phone: (239) 246-8751 Fax: (239) 220-5610

www.speechmatters239.com

jen@speechmatters239.com

Case History Form

General Information

Child's Name: _____ Date of Birth: _____ Sex: M F

Address: _____

Phone Number: _____ School: _____

E-Mail: _____

Who can we thank for referring your family to Speech Matters? _____

Insurance Plan Name and Number: _____

Primary Doctor: _____ Phone Number: _____

Other Doctor's/Specialists and Phone Numbers:

_____

_____

_____

Family Information

Child lives with (Circle): Birth Parents Parent and Step-Parent Adoptive Parents
One Parent Foster Parents Other _____

Mother's Name: _____ Occupation: _____
DOB: _____ Place of Work: _____
Father's Name: _____ Occupation: _____
DOB: _____ Place of Work: _____
Other (Spouse, Guardian, etc.): _____ Occupation: _____

Other Children in the Family:

Name	Age	Sex	Grade	List any speech or language problems

Was your child adopted? If so when? _____

Daytime Caregiver(s) for Child (Circle): Parent Grandparent Spouse Guardian

Daycare Babysitter/Nanny Other _____

Is there another language spoken in the home besides English? (Circle): Yes No

If yes, what language & who speaks the language(s)? _____

Does your child speak the language? (Circle): Yes No

Does your child understand the language? (Circle): Yes No

Pregnancy and Birth Information

How many living children in the family? (Circle answers) 1 2 3 4 5 6

Which pregnancy was this child? 1 2 3 4 5 6

During the pregnancy with this child was there: (Yes or No)

Early Labor _____ Bleeding _____ Illness _____ Diabetes _____ Smoking _____

Toxemia _____ Chemical or Substance Abuse _____ Other _____

Were there any other conditions or anything unusual that may have affected the pregnancy, birth, or first few weeks of infant life?

_____

Length of pregnancy: _____ Length of labor: _____

Birth Weight: _____

Were there any complications during delivery? Explain:

_____

Other pregnancy/delivery information: _____

Medical Information

Please provide the approximate ages at which the child suffered the following illnesses and conditions if applicable:

Asthma _____ Allergies (to what) _____

Chicken Pox _____ Colds _____

Convulsions _____ Croup _____ Dizziness _____

Draining Ear _____ Ear Infections _____

Encephalitis _____ Headaches _____ Head Injuries _____

Other _____

Has your child had any surgeries? If yes, what type and when? (Tonsillectomy, tube placement, etc)

_____

_____

Please list the medications and dosages your child takes regularly:

_____

_____

Developmental Information

Please provide the approximate age at which the child began to do the following activities:

Crawl _____ Walk _____ Sit _____ Stand _____ Feed Self _____

Dress self _____ Use toilet _____

Does the child have difficulty walking, running, or participating in other activities, which require small or large muscle coordination?

_____

Are there currently, or have there ever been, any feeding problems? (Problems with sucking, swallowing, drooling, chewing, etc.)?

_____

Circle all that apply to your child's response to sound:

Responds to all sounds Responds to loud sounds only

Inconsistently responds Other _____

Educational Information

List the schools attended, including any preschool or daycare programs

School	**Address**	**Grade and Dates Attended**

Current grade level: (Circle) Preschool Kindergarten 1 2 3 4 5 6 7 8 9 10 11 12

Concerns about your child's performance in school:

_____

With whom does your child spend most of his/her time? _____

Does your child eat well? (Circle) Yes No

Does your child sleep well? (Circle) Yes No

Does your child get along with other children? (Circle) Yes No

Does your child get along well with adults? (Circle) Yes No

Does your child present any behavioral problems? If so, explain.

At home _____

At school/daycare _____

In the neighborhood _____

<u>Speech and Language Information</u>

Please provide the approximate age at which your child began to use the following means of communication:

Babble and coo _____ Gesture _____

Using single words with meaning (no, mom, doggie, etc.) _____

Combining words (me go, daddy shoe, etc.) _____

Naming simple objects (dog, car, tree, etc.) _____

Has your child ever had a speech evaluation or speech therapy? (Circle) Yes No

If yes, when, where, & with what outcomes?

_____

_____

Has your child received any other evaluation or therapy? (physical, occupational, counseling, vision, etc.) (Circle) Yes No

If yes, please explain: _____

_____

Does your child hesitate and/or repeat sounds, words, or phrases? (Circle) Yes No

Does your child retrieve/point to common objects upon request? (ball, shoe) (Circle) Yes No

Does your child respond accurately to yes/no questions? (Circle) Yes No

Please describe your concerns for your child's speech-language development:

_____

_____

_____

_____

When & by whom were differences in speech/language first noticed?

_____

Please provide any additional information that might be helpful in the evaluation or treatment planning process. Also list any other concerns or questions you have at this time.

_____

_____

_____

Name of person completing this form: _____

Relationship to child: _____

Signature: _____ Date: _____

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Release of Information

I, _____, parent of
_____ do consent for Speech Matters to release, share, and exchange information regarding this patient to the following entities:

_____
_____
_____
_____
_____
_____

I do NOT consent for Speech Matters to release, share, and exchange information regarding this patient to the following entities:

_____
_____
_____
_____
_____
_____

Signature & date: _____

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Cancellation Policy

In order to serve all of our families to the best of our ability, we need to adhere to an attendance policy. Regular attendance is important for progress in speech-language therapy. The treatment plan is written with specific goals and outcomes for each individual. It is difficult to demonstrate progress in therapy when excessive absences occur.

If you or your child are unable to make his/her scheduled appointment, contact us as soon as possible.

We will need **to discharge patients** who have two (2) "no shows", or have cancelled 2x without 24-hour notice, within each six-month authorization period.

We understand that the unexpected will occur. Our goal is to have times accessible for your family's needs. We will make every effort possible to reschedule a missed appointment, in which case the cancellation will not be included as one of the two (2) allowed missed visits.

Thank you for your cooperation.

I, _____, understand the attendance policy. I commit to attending treatment sessions as scheduled.

_____

Signature/Date

Policies

Patient Information:

Name (First, MI, Last): _____ Birth Date: _____

Sex (Circle): M F

Emergency Contact (not living in household): _____

Phone Number: _____ Relationship to Patient: _____

Party Responsible for Payment: ____ Mother _____ Father _____ Other (fill out below)

Name: _____

Address:

_____

Home Phone: _____

Please read and initial each portion of the following and sign below:

I have read and understand Speech Matters financial policy and agree to the terms and conditions therein.

Initials _____

Speech Matters will occasionally take photos or videos of the patients during therapy sessions for purposes of marketing, advertising, etc. I understand that photos and video of my child may be used in brochures, newsletters, social networking sites, etc. and authorize such use.

Initials _____

*If you do NOT authorize photo release, please indicate here. We will not take any photos of your child per your wishes.

Initials _____

Supervision

All children require adult supervision at all times. It is NOT appropriate to leave children alone in the waiting area and it is NOT SAFE to allow them to roam unsupervised in the treatment rooms. We encourage parents to be in therapy sessions whenever possible. This includes

bringing siblings into the room if they can restrain from disrupting treatment. If clients do not do well with parents in the room or siblings are distracting you will be asked to stay in the waiting area. Your children are responsible for cleaning up after themselves. Please be responsible.

Speech Matter reserves the right to refuse services at the therapist/owner discretion.
Initials _____

I authorize the release of any information necessary to process this claim.
Initials _____

Treatment services may be provided by a licensed SLP-A under the directions of supervising SLP as per Florida Department of Health regulations, statute 64B20.4-0003
Initials _____

I certify that the information I have given is true and correct to the best of my knowledge. I will notify you of any changes in my child's health status or the personal information I have given.

Signature _____ Date _____

Medicaid Coverage
I have been informed of Medicaid coverage requirements.

Signature _____ Date _____

Financial Policy

Purpose:
Speech Matters is committed to providing quality and affordable care to patients it serves. We respectfully expect that payment is due by all individuals at the time services are rendered.

Policy:
To ensure all patient balances are appropriately billed and collected.

Procedure:
The following guidelines are to be followed during the billing and collection process:

Insurance:
Speech Matters participates in most insurance plans. Speech Matters will bill the patient's insurance company as a courtesy. The patient's insurance company may request patients to supply certain information directly; it is the responsibility of the patient to comply with their request. The patient is directly responsible for the balance of their claim whether or not their insurance company pays the claim. The patient's insurance benefit is a contract between the patient and the insurance carrier; Speech Matters is not a party to that contract. If Speech

Matters does not participating in a patient's insurance plan, we will grant the patient an agreed upon discount on services for balances paid in full at the time of service.

Referrals:

It is the patient's responsibility to obtain referral or necessary insurance pre-authorization prior to the time of their visit or procedure. The patient will be seen when required documents are received in our office.

Co-Payments and Deductible:

All co-payments and deductibles must be paid at the time of service. This arrangement is part of the patient's contract with their insurance company. Speech Matters cannot interfere with that contractual relationship.

Not Covered Services:

Some if not all services a patient receives at Speech Matters may be non-covered or not considered reasonable or necessary by insurers. Patients must pay for these services at the time of their visit.

Proof of Insurance:

All individuals must complete our patient information form before seeing the therapist. In addition, a current copy of your valid insurance card is necessary to confirm proof of insurance. If the patient fails to provide this information in a timely manner, they will be responsible for the balance of their claim.

Methods of Payments:

Speech Matters accepts payments by cash, check, VISA, MasterCard, and Discover.

Patient Statements:

Unless other arrangements are approved by Speech Matters in writing, the balance of the patient's statement is due and payable when statement is issued, and is considered past due if not paid within 30 days of issuance.

Nonpayment:

If the patient's account is past due 90 days or greater and the balance has not been paid in full or payment arrangement made, the account may be sent to collections. Until balances are paid in full, therapists will treat patients on an emergency basis for previously treated injury or problem. Any allowed visits will require cash or credit card payment in full at the time of service, unless they have valid insurance. Patients may be terminated due to non-payment. If the patient has filed bankruptcy during the course of treatment, any future visits need to be paid by cash or credit card if the patient does not have valid insurance. If there is a valid insurance, any co-payments or deductibles need to be paid at the time of service.

Divorce:

In the case of divorce or separation, the party responsible for the account balance is the parent authorizing treatment for the child. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Returned Checks:
A $35.00 service fee will be added to all checks returned for insufficient funds. If you check is returned, you will be required to pre-pay all future services at the time of service by cash, money order, or credit card.

Credit Balance Refunds:
Speech Matters will make a good faith effort to capture all accounts that have been overpaid by a patient or insurance carrier and to refund the appropriate party within a reasonable time frame.

A refund will be issued when:

- A patient paid more than was based on their contractual agreement with their insurance carrier, and there is no other outstanding balance due by that patient to which the credit can be applied.
- A patient or insurance carrier erroneously issues a duplicate payment
- A payer erroneously remits payments to the wrong provider.
- The payer originally remits payment for a service that is later determined to be a non-covered service. In the situation, a refund may need to be issued to the payer, and a bill issued to the patient if said non-covered service is deemed by their insurance to be a patient responsibility.
- The patient paid an assessed co-pay/co-insurance/deductible and it was later determined that a secondary insurance was responsible for this balance.

Refunds will not be issued:

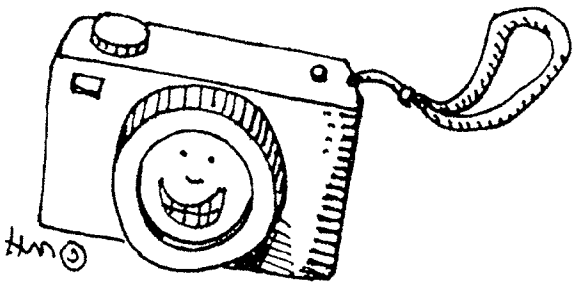
- If insurance is pending payment
- When there is a pre-existing balance due on the patient's account.

Thank you. We appreciate your business and look forward to a productive time together.

* Preferred Times for Treatment Session

Time	Monday	Tuesday	Wednesday	Thursday	Friday
8:00 AM					
9:00 AM					
10:00 AM					
11:00 AM					
12:00 PM					
1:00 PM					
2:00 PM					
3:00 PM					
4:00 pm					
5:00 pm					
6:00pm					

Social Media Permission Slip



Patient Name: _____

Please select below whether or not you give permission for your child's picture to be posted on our Speech Matters social media accounts. Your child's personal information will never appear.

_____ I **GIVE** permission for my child's picture to be posted on social media.

_____ I **DO NOT** give permission for my child's picture to be posted on social media.

Parent Signature:_____

Date: _____

Thank you!

Speech Matters

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HIPAA-ACKNOWLEDGEMENT OF RECEIPT

Notice of Privacy Practices Printed Patient Name: _____

Patient Birth Date:_____

We at Speech Matters are required by law to maintain the privacy of and provide individuals with the Notice of our legal duties and privacy practices with respect to protected health information. If you would like a copy of the Notice, please ask.

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

_____ _____

Signature of patient or patient's representative/parent Date

_____

Printed name of patient or patient's representative/parent

_____

Relationship to patient