ACHIEVING BETTER COMMUNICATION

Child's
Name:_____Date:_____

You are receiving this packet because your child may benefit from speech and/or language therapy. Please complete the attached forms and return to your teacher, director, or directly to the office via email (info@abcspeechnc.com) or by fax (919-926-1377). Call us if you have any questions. **Once the attached form is received** we will be in touch to schedule your initial assessment.

Thank you for allowing us to provide clear and confident speech and language therapy services.

Sincerely,

Tammie Locklear, M.Ed., CCC-SLP

Tammie Locklear, Clinical Director
Achieving Better Communication, PLLC

503 US Highway 70 E #K Garner, NC 27529
O. 919.926.1466 / F. 919.926.1377
info@abcspeechnc.com / www.ABCspeechNC.com

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NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

PLEASE REVIEW THIS NOTICE CAREFULLY

Our Commitment to Your Privacy:

Achieving Better Communication, PLLC (ABC, PLLC) is committed to maintaining the privacy of your child's speech and/or language evaluation findings and/or treatment. In conducting our daily business, we will create records regarding your child's treatment and services we provide. We are required by law to maintain the confidentiality of identifiable information of your child. As a parent or guardian, you have the right to revoke policies listed below at anytime by contacting TAMMIE LOCKLEAR in writing. All pertinent information used for the purpose of providing speech and/or language services prior to this revocation cannot be overturned.

a. **ABC, PLLC and its employees are authorized to use or disclose any information that is pertinent or required for speech and language therapy services.**

b. **All pertinent health information will be secured at all times from public access.**

c. **Only employees of ABC, PLLC who have signed a confidentiality agreement will be able to access pertinent health information.**

d. **All pertinent health information related to the evaluation and treatment of speech and/or language delays/disorders will be provided to your insurance company, other payer sources, and referring physician for the purpose of doctor's orders and authorizations/reimbursement of services. All information will be sent via fax or USPS mail. Date and time will be documented upon submission and re-submission if needed.**

e. **Confidential information is not shared with 3rd parties other than those listed above without prior authorization of release of information signed and dated by parent or guardian with the receiving parties' identifying information.**

f. **Employees are authorized to share information with each other and the referral source (e.g. case manager, teacher, social worker) to provide the best possible service to our patients.**

g. **Employees are authorized to store pertinent information (e.g. progress notes, evaluations) on their personal/office computers with a secure password created by ABC, PLLC and only known by employees. Confidentiality agreement will include that employees (including those who resign or are terminated) will not divulge of the secure password. ABC, PLLC reserves the right to change the password at any time.**

h. **Employees are authorized to login to a HIPPA compliant secure network "Clinic Source" hosted by Ingenium Business Solutions, Inc. for the purposes of scheduling, documenting and billing. Employees are given an individual username and password for online access. Confidentiality agreement will include that employees will not divulge of the secure password. Terminated or resigned employees will be deemed inactive in the system.**

i. **Employees are authorized to email pertinent information for the purpose of daily business functions between office management and themselves as an attachment only and containing the same secure password to open the document as discussed above.**

j. **By contacting ABC, PLLC via email or other internet source, the parent or guardian is responsible for any confidential information that may be lost or breeched over the internet.**

k. **ABC, PLLC reserves the right to revise or amend these policies at any time. An amended policy will be provided to parent or guardian upon request.**

l. These authorizations will expire upon date of patient discharge from ABC, PLLC.

Revised 04/2013

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Case History Form

Patient Information: Date: _____

Person Completing Form: _____ Relationship to Child: _____

Child's Name: _____ Date of Birth: _____

Gender: Male Female

Address: _____ City/Zip: _____

Parent(s)/Guardian: _____

Email: _____ Contact Person Phone#: _____
(please circle: cell home business)

May we communicate pertinent health information via: (please circle yes or no)

Voicemail? Yes No Text Message? Yes No Email? Yes No

When did you first become concerned with child's speech and language? _____

Is child's speech easily understood by family members? _____ Others: _____

Intelligibility of speech to familiar listeners? Easily Somewhat To unfamiliar listeners? Intelligible Unintelligible

Previous speech and language evaluations: Yes No If yes, please provide date(s) and agency _____

_____ Has previous speech therapy been discharged? Yes No

Physician and Insurance Information:
Pediatrician: _____ Phone: _____

Address: _____ Fax #: _____

Insurance Carrier: _____

Policy/Medicaid Number (please provide alpha characters): _____
(please provide a copy of insurance card, front & back)

Family Information/History:
Other languages spoken in the home: _____

Other Family members in the home: (include ages, relation, and history of speech disorder)

_____

_____

_____

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Location of Therapy: We strive to accommodate all location requests.

Where do you want therapy to take place? Home Daycare School Office (please circle one).

Alternative:_____

Location Name and Address:_____Location phone #:_____

Patient Medical History:

Prenatal and Birth History:

Mother's general health during pregnancy (illness, accidents, medications, etc.)

_____

_____

Length of Pregnancy: _____Length of Labor: _____

Term: _____Birth Weight: _____Type of Delivery: Normal Caesarian

Were there any unusual conditions that may have affected the pregnancy or birth? _____

_____

Medical History:

Provide the approximate ages at which the child suffered from any of the following illness/ conditions:

Allergies:	Asthma:	Chicken Pox:
Colds:	Convulsions:	Croup:
Dizziness:	Draining Ear:	Ear Infections:
Encephalitis:	German Measles:	Headaches:
High Fever:	Influenza:	Mastoiditis:
Measles:	Meningitis:	Mumps:
Pneumonia:	Seizures:	Sinusitis:
Tinnitus:	Tonsillitis:	Accidents:

Were there any changes in speech from the illness or conditions listed above?_____

_____

Surgery/Injuries: _____Medications: _____

Is the Patient's condition related to recent hospitalizations and/or illnesses? Yes No, If yes, please explain:

_____

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Hearing:

Date of last hearing screening: _____Last Audiological Evaluation: _____

Otological care or surgery: _____

Do you have specific hearing concerns? Yes No, If yes, please explain: _____

_____

Developmental History:
Provide the approximate ages at which the child began to do the following activities:

Activity:	Age		Age
Crawl		Toileted	
Sit		Use single words	
Stand		Combine words	
Walk		Name simple objects	
Feed Self		Use simple questions	

Specific delays: _____

School and Speech History:

School: _____ Grade: _____

Strengths and Difficulties:_____

Special Services: _____

Does your child have an Individualized Education Plan (IEP)? Yes No

If yes, are they receiving Speech Therapy in school as part of their IEP? Yes No

If yes, please provide details (i.e. how many times per week, group or individual therapy)_____

_____

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Patient Name: _____ DOB: _____

Address: _____

Primary Insurance Carrier/Policy Number: _____

Permission to Evaluate and/or Provide Therapy

The following gives the Speech-Language Pathologists of Achieving Better Communication, PLLC permission to provide your child with a comprehensive speech and/or language evaluation (diagnostic measures to include standardized testing, clinical observations, parent/teacher interview etc.) and provide treatment, if indicated from the evaluation findings.

I, _____ (Parent or Guardian), authorize **Achieving Better Communication, PLLC** to evaluate and provide the appropriate/necessary therapy/treatment for _____ (Child's Full Name) in the areas of speech and/or language. Treatment is dependent upon the responsible speech-language pathologist's findings and recommendations.

Insurance Collection Policy

We, at Achieving Better Communication, PLLC are aware that your child's speech and language therapy is your main priority. We are also aware that you would like us to bill your insurance company for services rendered by Achieving Better Communication, PLLC. With this billing option, we will verify you benefits as a courtesy and submit your insurance company with any pertinent information (evaluation, treatment goals) needed to complete your insurance claims. We CANNOT guarantee benefits. You are encouraged to contact in your insurance company to verify benefits as well. You will also be responsible for any co-pays required by your insurance company that will be billed directly to you on a monthly basis by Achieving Better Communication, PLLC. Invoices will be provided via email ONLY. If the insurance company denies all or part of your claims filed, you are responsible for payment of services.

I have read and understand Achieving Better Communication's Insurance Collection Policy and accept all terms and conditions.

Notification of Physician or Insurance Changes

I agree to notify Achieving Better Communication, PLLC of any changes in my child's physician or insurance coverage prior to the date of change.

Notice of Privacy

I have received a copy and reviewed the NOTICE OF PRIVACY PRACTICES from Achieving Better Communication, PLLC and understand that this agency will comply with all HIPPA regulations.

_____

Signature of Parent/Guardian **Date**

_____

Speech-Language Pathologist **Date**

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