



Thank you for making your appointment with The Speech and Hearing Center on

_____ at _____

Enclosed in this package is an Intake Form, Case History, Consent to Exchange Information, Consent to Comply with Federal HIPAA Act, Financial Policies Review and Directions to our location.

Please complete the enclosed forms and return to our office with a copy of your insurance card, prior to your appointment. This will help us get you started on time for your scheduled appointment.

The completed forms can be returned to our office by fax at (423)622-4834, by mail at 6016 Shallowford Road, Suite 1500, Chattanooga, TN 37421 or they can be delivered to our office in person.

Please arrive **15 minutes** prior to your scheduled appointment time to allow extra time for intake before seeing the Speech-Language Pathologist or Audiologist.

If you have any questions before your appointment, please give us a call at (423)622-6900.

Thank you,

The Speech and Hearing Center

6016 Shallowford Road, Suite 1500, Chattanooga, TN 37421
433 North Ocoee Street, Cleveland, TN 37311
Phone: 423-622-6900 Fax: 423-622-4834
www.speechhearing.com



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Chattanooga, TN 37421
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CHILD SPEECH CASE HISTORY-CONFIDENTIAL INFORMATION

TODAY'S DATE _____

Person completing this form: _____ Relationship to child _____

Who referred you to The Speech and Hearing Center? _____

Reason for visit _____

GENERAL INFORMATION

Child's Name _____ Preferred Name _____

Birth Date: _____ Age: _____ Sex: _____

Physician(Name and Address): _____

SPEECH AND LANGUAGE

Describe the child's current speech/language problem:

____ Age of first spoken word _____ Age of first spoken sentences

Describe the child's communication at the present time. (Please check all that apply.)

<input type="checkbox"/> Grunts and Points	<input type="checkbox"/> Copies What You Say	<input type="checkbox"/> Stutters
<input type="checkbox"/> Screams	<input type="checkbox"/> Single Words	<input type="checkbox"/> Too Soft
<input type="checkbox"/> Gestures	<input type="checkbox"/> Two-Word Phrases	<input type="checkbox"/> Too Loud
<input type="checkbox"/> Takes You To Object	<input type="checkbox"/> Longer Sentences	<input type="checkbox"/> Hoarse
<input type="checkbox"/> Copies What You Do	<input type="checkbox"/> Unclear Speech	

Indicate any family history of speech or language problems: _____

Has child received any developmental evaluations prior to today? If "Yes", please explain. YES NO

School/Daycare: _____ Grade: _____

Is the child enrolled in any special education classes? YES NO

Has the child received previous speech/language therapy? YES NO

Is the child currently receiving speech/language services? YES NO

Comments about School: _____

DEVELOPMENT

At what age did the following first occur?

_____ Sat Up Alone	_____ Crawled
_____ Walked Unaided	_____ Gained Bladder Control

Does the child appear clumsy or awkward? YES NO

Has the child received any intervention or therapy for motor development? YES NO

PRENATAL/BIRTH HISTORY(Questions apply to the birth of this child.)

Mother's illnesses, accidents or infections during pregnancy: _____

Which of the following did the mother experience during pregnancy?

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> X-rays | <input type="checkbox"/> Drug/Alcohol Problems | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Medication | <input type="checkbox"/> Surgery | <input type="checkbox"/> Accidental Injury |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Toxemia | |

Length of Pregnancy _____ Length of Labor _____

Any complications at delivery? _____

Did the child experience any of the following conditions immediately following birth?

- | | | |
|---|--|--|
| <input type="checkbox"/> Breathing Difficulties | <input type="checkbox"/> Oxygen Needed | <input type="checkbox"/> Feeding Problems |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Seizures | <input type="checkbox"/> Sucking/Swallowing Problems |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Infections | |

Were there any other abnormalities or conditions not already mentioned? _____

MEDICAL

Please check all that apply

- | | | |
|---|--|---|
| <input type="checkbox"/> High Fever | <input type="checkbox"/> Other Injuries | <input type="checkbox"/> Eating/Swallowing Problems |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Hospitalizations | <input type="checkbox"/> Wears Glasses |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Illnesses | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Operations | <input type="checkbox"/> Wears a Hearing Aid |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Medications | <input type="checkbox"/> Behavioral Problem |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diagnosed with ADHD/ADD | |
| <input type="checkbox"/> Head Injuries | | |

Please explain the items checked: _____

Describe any physical disability or condition: _____

Is the child currently taking any medications? If so, please list: _____

FAMILY INFORMATION

Father's Name: _____ Mother's Name: _____

Father's Age: _____ Education: _____ Mother's Age: _____ Education: _____

Marital Status: Single Married Divorced Widowed Separated

Others Living in Child's Home:

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____



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CONSENT TO EXCHANGE INFORMATION

Patient's Name: _____ Date of Birth: _____

Current Address: _____

Telephone Number(s): _____

I hereby give my consent for The Speech and Hearing Center to exchange information with:

(Name and Address of Agency/Individual; for example: Referring Physician, Family Member, Spouse or other Guardian, Educator or Agency)

Information exchanged may include but is not limited to speech/language and hearing records, medical reports, academic information and program planning. Information may be shared through written reports, by phone, fax or in person.

All of the information I hereby authorize to be exchanged with the above, will be held strictly confidential and cannot be released without my written consent. I understand that I have the right to inspect and copy the information to be disclosed. I understand that I may withdraw this authorization at any time.

This request is effective up to and including one (1) year from the date of signature.

- By checking this box, you authorize The Speech and Hearing Center to periodically send you, via email or U.S. Mail, helpful information related to communication disorders, special promotions The Center may have to offer, and/or information about special fundraising events to benefit the Center.

Signature of Consenting Party

Relationship to Patient
(must be legal guardian/conservator)

Date

CONSENT TO COMPLY WITH FEDERAL HIPAA ACT

Patient Consent for Use and Disclosure of Protected Health Information

With my consent and signature, The Speech and Hearing Center may use and disclose protected health information about me or my child to:

1. Carry out treatment, payment and healthcare operations (services).
2. Call my home or other designated locations and leave a message on voice mail in reference to any items (i.e. appointment reminders, insurance items, references to clinical care of laboratory results, etc.) that will assist in the practice of medical care for me or my child.
3. Mail to my home or other designated address any item (i.e. appointment reminder cards, patient financial statements, etc.) that will assist in practice of medical care for me or my child. Such correspondence is to be marked personal or confidential.
4. Send or transmit email to any location provided by me for all above similar items and purposes.
5. To use and/or disclose protected health information about me or my child to/with third parties involved in mine or my child's care. Such parties may include, but are not limited to, insurance companies, hospitals, specialty physicians and laboratory personnel. I may specifically describe the type of information (i.e. dates of services, level of detail, origin of information, etc.) subject to disclosure and may revoke this permission at a time and date chosen by me. By providing a written statement to the privacy office of The Speech and Hearing Center, I may revoke this permission; however, The Speech and Hearing Center may decline to provide further treatment to me or my child. The Speech and Hearing Center may also decline further treatment to me or my child should my restrictions on the type of third party information, in the Center's opinion, impede medical care of me or my child.

I have the right to review the Notice of Privacy Practice Manual of The Speech and Hearing Center. The Speech and Hearing Center may revise its manual and procedures at any time deemed necessary, and I may request from time to time, in writing, a copy of such changes, should these changes directly relate to mine or my child's care.

I have the right to request that The Speech and Hearing Center restrict how it uses or discloses mine or my child's health information. However, as stated previously, The Speech and Hearing Center is not required to agree to my restrictions. If The Speech and Hearing Center accepts my restrictions, The Speech and Hearing Center is then bound by the restriction in the agreement, setting forth the restricted information until providing me, in writing, a cessation of such agreement.

I may revoke this entire consent, in writing, at any time. If I do not sign this consent or revoke this consent, The Speech and Hearing Center, in their sole discretion, may decline further treatment for me or my child.

The HIPAA Privacy Act of 2001 was created to protect mine and my child's health information. I understand this must be accomplished within the provisions and rules set up by The Speech and Hearing Center to fulfill federal law. I may request to review the manual which spells out these provisions. The Speech and Hearing Center will comply with this law to preserve privacy. If compliance with this law impedes the medical care of the patient, The Speech and Hearing Center may decline to provide further care. The Speech and Hearing Center will strive to provide information so that I may make an informed decision concerning the privacy of mine or my child's medical information.

Signature of Parent or Legal Guardian of Minor Child

Date of Signature

Patient's Name

Date of Birth

Printed Name of Signature Above

Initials of Witness



FINANCIAL POLICIES REVIEW

Thank you for choosing The Speech and Hearing Center for your speech and audiology needs.

General Financial Policy of the Center:

The Speech and Hearing Center is a non-profit organization providing services for the community for both those in need and those who are able to afford our services. In order to keep our administrative costs as low as possible, we require payment at the time of services and do not send out billing statements. The Center will provide notification of missed payment as early as possible by sending a statement that is due upon receipt.

If we participate with a commercial insurance plan under which you are covered, we will bill the carrier charges for all covered, medically necessary services rendered. Your signature authorizes payment of medical benefits to the provider when an assigned claim is filed. You will be responsible for deductibles, co-payments and any non-covered services at time of service.

If we do not participate with your commercial insurance plan or you do not have insurance, you will be responsible for payment in full at time of service.

We accept Visa, Mastercard, Discover, American Express, personal checks and cash. Financing is also available through Care Credit.

If a patient is seen off site or attends appointments without the financially responsible person, The Center requires that a credit card be on file to process payment for services on the day or the day following the provided service.

Speech Therapy Patients: The Center will file insurance for in-network BCBS, BlueCare, United Healthcare and Medicare patients, but often developmental speech services are not covered by commercial insurance plans. The Center will not continue to file claims for services that are determined to be uncovered by an insurance provider. Uncovered services are not applicable to your deductible for most plans and you will be responsible for payment at time of service.

Received and Acknowledged by Patient or Responsible Party:

Signature: _____

Name: _____

Date: _____

Directions to The Speech and Hearing Center

The Speech and Hearing Center
6016 Shallowford Road
Suite 1500
Chattanooga, TN 37421
423.622.6900



Directions from Highway 153 South (from Hixson):

- Take Exit 2- Shallowford Road
- Stay in left two lanes to turn onto Shallowford Road
- Turn right on the service road across from the Waffle House just before Service King
- Stay right at the median and continue around the bend until you see Car Express on your left
- Our office is located to the left of Ankar's Express Café at Friar's Branch Crossing

Directions from Highway 153 (from I-75)

- Take Exit 2- Shallowford Road
- At the light turn right onto Shallowford Road
- Turn right on the service road across from the Waffle House just before Service King
- Stay right at the median and continue around the bend until you see Car Express on your left
- Our office is located to the left of Ankar's Express Café at Friar's Branch Crossing