Authorization Sheet

Therapy Information & Authorization Sheet

Patient Name: ____________________ School: ____________ Doctor: ____________
Address: ______________________________City/State/Zip: ______________________
Guardians Name:______________________________ Phone: ____________________
Emergency Contact:______________________________ Phone: ____________________
Email: ____

Does your child have an Individualized Educational Plan (IEP)? Yes or No
If yes, with which agency? Please list contact information so that a copy may be obtained:
____

Insurance type: □Medicaid □CHIPS □Tricare □United Health Care □Blue Cross Blue Shield □Magnolia
□Other:____________________________
Insurance Policy Number: ______________________ Insurance Phone Number: ______________

I hereby authorize/give permission to a license therapist/aide to provide therapy services for me/my family member as the need is indicated by his/her attending physician, and/or use the protected health information. I also authorize the Speech therapy staff/aide to screen and/or evaluate the above named patient. Please be advised that a Speech Therapy Aide works under the supervision of a licensed Speech Language Pathologist, and provides support activities for the SLP. SLP aides may not be responsible for or perform diagnostic or evaluative procedures, nor represent themselves as an SLP.

Information to be disclosed: •Medical Records •Treatment Records • Diagnostic Records

I certify that the information given by me in applying for payment under Title XVIII, XIX and Medical Services Administration is correct, I authorize any hold of medical or other information about me to release any information needed for this or any related claims. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.

You may inspect or copy the protected health information to be used or disclosed under this authorization. I request payment of authorized benefits be made on my behalf. I agree to the services being provided and assigned the benefits payable for therapy services to the therapist providing the services.

The following categories describe different ways that we use and disclose medical information: Payment- We may use and disclose medical information about the patient so that the treatment and services received may be billed to and payment may be collected from you, an insurance company, or a third party and Treatment- we may use medical information about patient to provide therapy services.

You have the following rights regarding medical information we maintain about the patient: •Right to a paper copy of this notice •Right to inspect and copy •Right to amend •Right to request restrictions (We are not required to agree to your request) • Right to restrict disclosures to Health Plan •Right to request confidential communications •Right to an accounting of disclosures.

Changes to this notice: We reserve the right to change this notice. Patient will be notified of any changes made to notice.

Finally, you may revoke this authorization in writing at any time be sending written notification to licensed therapist and it will be effective on the date of notification. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

In consideration of these services received or to be received, I hereby authorize payment to licensed therapist for insurance benefits. I understand I am financially responsible to licensed therapist for charges not paid or covered by this authorization.

Signature:______________________________ **Date:**__________________________

Case History Form

Patient Name:	Date of Birth:	Sex:	Phone Number:
			Home:
Address:	Dr. Name		Cell:
			Alternate:
Emergency Contact Info:	Relationship		Home:
			Cell:

Family History	Relation to Pt.	Speech/Language/Hearing /Other Problems	Speech History	Age of Occurrence
			Please guess or estimate what age your child:	
			said their first word (such as mama, dada, ball, bye)	
			said two words together (such as me go, want drink)	
			said three words together (such as me want drink)	

Health/Language History	Yes	No	Birth History	Yes	No
Do you feel your child have any trouble saying words?			Did mother have any health problems during pregnancy or delivery? If yes what?		
Do you feel your child has hearing problems?			Did mother visit doctor fewer than 2 times during pregnancy?		
Has your child ever had ear infections? If yes, how many?			Was child born more than 3 weeks early? If yes, how many weeks at birth?		
Has your child ever had Eustachian tubes placed in ears? If yes, when?			How was child delivered? Please circle: Normal or C-Section ***How much did child weigh at birth?*** ________________		
Does your child have any visual problems?			Was child ever in neonatal intensive care unit (nicu)?		
Does your child have Asthma, allergies or sensitivities?			**Developmental History**	Yes	No
Is your child on any medications? List:			Was your child late sitting up?		
Does your child have difficulty following directions? (get your shoes, shut the door)			Was your child late crawling?		
Does your child have trouble getting enough air for talking?			Was your child late walking?		
Does your child repeat words over and over?			Was your child late talking?		
Does your child use gestures more than talking?			Was your child late feeding themselves?		
Does your child use words to make wants and needs known?			Was your child late being toilet trained?		
Has your child ever had speech therapy? When and where?			Was your child late understanding directions?		
Does your child respond correctly to yes/no questions?			Was your child late dressing themselves?		
Does your child respond correctly to who/what/ Where / when/ why questions?			**Most recent Doctors Visit?** **Doctor: Where: When:**		

Additional Information (Check as many as applies)									
Adenoidectomy		High fevers		Sleeplessness		Colds		Breathing difficulties	
Poor eating habits		Measles		Nightmares		Flu		Thumb/finger sucking	
Tonsillitis		Meningitis		Refusal to obey		Mumps		Running away	
Chicken pox		Strong Fears		Fighting		Lying		Difficulty playing with others	
Temper tantrums		Scarlet fever		Jealousy		Stealing		Hurting other children	
Strong dislikes		Seizures		Fatigue		Sinusitis		Poor eye contact	
Head injury		Tonsillectomy		Easily distracted		Stubborn		Easily frustrated	

Additional Information/Comments:

____

____

____