

Patient Referring Physician:	DOB: Primary Care Physician:	CA:	Date of evaluation
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Person completing form	Relationship to patient
Please describe your concerns about your child's speech/language/swallowing or hearing development	

**Medical History**

Describe any complications during pregnancy or delivery: <input type="checkbox"/> Toxemia <input type="checkbox"/> Maternal diabetes <input type="checkbox"/> Premature birth <input type="checkbox"/> Low birth weight <input type="checkbox"/> C-section.	
Describe any special health, feeding problems or hospitalizations your child has had:	
How many ear infections has your child had?	Has your child had tubes in the ears? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, when?

**Developmental History**

Describe any delays in development that your child has experienced:		
Does he/she play well with other children? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have concerns about your child's ability to learn? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you think your child could benefit from social or psychological counseling? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Who lives in the home?	Number of brothers?	Number of sisters?

**Educational History**

Where is your child enrolled in preschool or school? (Please list)	Grade level?	How many days a week?
Does your child have any difficulty communicating there? If so, please describe.		
Describe any concerns with attention, behavior, learning or interaction with classmates.		
Describe your child's progress socially and academically.		
Is the child currently enrolled in Speech Therapy?	Is there an IEP/IFSP?	(Need Copy)

**Speech and Language History**

How does your child primarily express himself/herself? <input type="checkbox"/> Gestures/signs <input type="checkbox"/> Sounds <input type="checkbox"/> Words <input type="checkbox"/> Sentences <input type="checkbox"/> Combination <input type="checkbox"/> Other	
How easy is it for you to understand your child's speech? <input type="checkbox"/> Very easy. I understand everything. <input type="checkbox"/> I occasionally understand. <input type="checkbox"/> Fair. I must know the topic to understand. <input type="checkbox"/> Very difficult to understand, even if he repeats. <input type="checkbox"/> Impossible to understand.	
How do you get your child to understand you?	
Describe what you do at home to improve your child's speech/language development	
Have your attempts helped?	How does your child respond to your efforts to help?
Has your child previously been evaluated for speech or language delay? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe any prior therapy and results.	

Who should receive a copy of the report?
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**Brief Pediatric Case History**

## WELCOME TO OUR PRACTICE

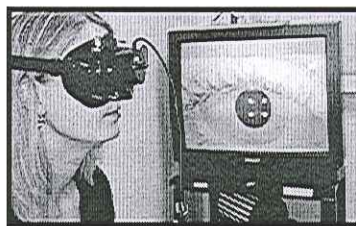
Welcome to our practice at Columbus Speech & Hearing Center! Your presence here means that you have taken the first step in changing a speech and/or language problem, something that affects 10% of our population. It will be our honor to help you meet your therapy goals in the shortest time possible. Our therapy journey will be one of cooperation, open communication, and mutual respect. We want your attendance here to be pleasant as well as beneficial to you or your family member's speech-language development. To help in that process, provided below is basic information related to therapy, billing, attendance, communication with staff, etc. If you have questions not answered below, do not hesitate to call or ask our staff.

**Services offered in the clinic:** Three basic types of services are offered:

- **Speech-language therapy** for young children through geriatrics. Our youngest patients are premature babies who were tube fed and later needed help learning to suck-swallow-breathe; our oldest are often stroke patients. They come from all walks of life, all socio-economic stratas, a range of occupations. Specialty programs include swallowing, reading, cognitive rehabilitation for memory loss, voice, and pediatric language development. Our staff provides services at The Medical Center, Doctors Hospital, Hughston Hospital, two nursing homes, Head Start, Brookstone School, and in this clinic.



- **Audiology services.** We have the only regional department staff whose diagnostic services are provided solely by doctoral level audiologists. They offer a complete range of hearing evaluations, assessment of dizzy/balance disorders, hearing aid sales and maintenance. They test the hearing of all newborn babies at Doctors Hospital and babies in the High Risk Nursery at the Medical Center. They provide complete hearing evaluations and dizzy/balance assessments for numerous local physicians in private practice, and for those at Martin Army Community Hospital. They are the Preferred Providers by the City of Columbus, for their employees.



- **Psychological services.** These services begin in January, 2010, provided by Dr. Rabia Subhani-Siddique. Dr. Siddique is licensed clinical psychologist specializing in pediatric neuropsychology. She is trained in ADOS (the gold standard for Autism Spectrum Disorders) and was triage coordinator at Emory's Autism Research Center. Services include evaluation and treatment for neurodevelopmental disorders (Autism, developmental delays), neuropsychological (attention, learning, memory), psycho-educational (skills needed for academic success and placement) and general psychological (cognitive functioning, personality, emotional functioning and adaptive skills).

***Factors affecting extent of progress and rate of progress for different speech-language disorders:***

A number of things are important, including the disorder itself – those with a neurological or physical cause are often more difficult to correct than developmental disorders. The more severe the disorder, the longer it takes to correct. A very important variable is the consistency and thoroughness with which home work is completed. Children cannot complete it alone, so parents must help, which means the parents must observe therapy on a regular basis to learn how to reinforce emerging new speech and language patterns at home. Parental observation of therapy is encouraged and welcomed! We need your help. The child needs your help. It makes the difference in a child's getting a few hours of therapy a month directly from the therapist, versus that same therapy contact supplemented by daily, almost hourly, reinforcement from parents in the child's home environment. Another crucial factor affecting progress is regular attendance. Therapy is planned in a sequential manner with predictable time frames between steps. If attendance is not regular, progress will be hindered and enthusiasm for the process may be affected. (See separate attendance policy).

***Contact information for staff:*** For all departments, call our main number (706-324-6112). If the therapist is not available, you will be routed to his/her voice mail, which is checked several times a day. It may be late in the afternoon before you get a return call, but it will be returned. If you need a faster response, tell the receptionist and she will get your message to the therapist between patients. Also, do not hesitate to ask for your therapist's email address. That can be an effective way to avoid playing phone tag. Other numbers include:

- **Billing:** Brandon Glover, Office Manager. 706-324-6112, extension 217.
- **Scheduling:**
  - **Amy Goodrich:** Clinic Coordinator. Ext.220
  - **Sheri Love:** Audiology Receptionist. Ext. 201
  - **Veta Haltrich:** Adult Receptionist, schedules adult speech patients for Dr. Ford, Dizzy/balance evaluations for Dr. Cellino and NeuroPsych evaluations for Dr. Subhani-Siddique. Ext.204
  - **Heather Martin:** Pediatric Receptionist. Ext. 202
  - **Martha West:** Insurance Questions. Ext. 216
  - **Ashley McMahan:** Medical Records. Ext. 203

***Insurance coverage:*** CSHC is an approved provider for major insurance companies including Medicare, Medicaid, Tricare, and most private companies, with the exception of United Healthcare. Upon request, our front office staff calls for prior authorization of therapy before services begin. This helps rule out some disorders not covered. In some cases, coverage is not clear ahead of time. The carrier may refuse to commit to coverage until after treatment is provided. In all cases, the patient is ultimately responsible for payment of services either not covered at all by insurance, or for their share of the cost when insurance is a partial payor. The patient share is expected at the time services are rendered.

**Hours of operation:** 8:00 AM – 5:00 PM, Monday through Friday. Someone is usually here by 7:45 AM to take early calls. Most therapy is between 8:00 AM – 5:00 PM.

**Holidays:** News Years Day, Memorial Day, 4<sup>th</sup> of July, Labor Day, Thanksgiving, Christmas Eve, and Christmas Day. Reminders are posted a week before each holiday.



**PATIENT INTAKE INFORMATION**

<b>PATIENT</b>	FILE:	SOC SEC #	SEX: M    F	MARITAL STATUS	BIRTHDATE	PHYSICIAN	OCCUPATION	
	LAST NAME		FIRST NAME		MI	EMPLOYER		
	IF PATIENT IS A MINOR:						EMPLOYER ADDRESS	
	Father's name:		Social security number		Address if different from below		WORK PHONE	
	Mother's name:		Social security number		Address if different from below		HOME PHONE	
	STREET ADDRESS						CELL PHONE	
	CITY		STATE		ZIP CODE		EMAIL	
REFERRAL SOURCE								

<b>RELATIVE</b>	LAST NAME		FIRST NAME		MI	RELATION TO PT:	
	STREET ADDRESS		CITY		STATE	ZIP CODE	PHONE:

<b>INSURANCE IDENTIFYING INFORMATION</b>	PRIMARY INSURANCE		SECONDARY INSURANCE	
	NAME OF INSURED			
	POLICY NUMBER			
	GROUP NUMBER			
	EFFECTIVE DATE			
	PAYER ID			
	CONTRACTED PLAN YEAR			
	TYPE PLAN: HMO, POS, PPO, INDEMNITY			
	IS CSHC IN NETWORK OR OUT OF NETWORK?			
DOES THE PATIENT RECEIVE ANY HOME HEALTH, HOSPICE OR SKILLED NURSING CARE?			YES	NO
DOES THE PATIENT RECEIVE SPEECH SERVICES AT ANY OTHER FACILITY?			YES	NO

<b>PATIENT VERIFICATION OF ACCURATE INSURANCE INFORMATION AND RESPONSIBILITY FOR PAYMENT</b>	
<p>I understand and agree that I am ultimately responsible for payment in full for any professional services rendered, regardless of my insurance status. I have read the information on this page and certify the information to be true and correct to the best of my knowledge. I understand that all claims are subject to individual contract policy and to medical necessity review. Prior authorization for a procedure is not a guarantee of payment. I will promptly notify you of any changes in my health status or the above information.</p>	
<p>_____ Patient signature/ or Parent if patient is a minor</p>	<p>_____ Date</p>

## SIGNATURE PAGE

**Instructions:** Please **initial** beside each of the following items, indicating your authorization or agreement.

Date	Yes, I agree	No, I do not agree	
			<b>CONSENT FOR TREATMENT</b> I hereby consent to such diagnostic procedures, and medical treatment, which in the judgment of my Physicians may be considered necessary or advisable while a patient at Columbus Speech and Hearing Center
			<b>ASSIGNMENT OF BENEFITS:</b> I hereby authorize payment directly to Columbus Speech & Hearing Center of the Medical Benefits, otherwise payable to me for services described above, but not to exceed reasonable and customary charges for those services. I understand and acknowledge that this assignment does not relieve me of my financial responsibility. If payment has not been received from the insurance carrier, <i>I accept personal liability for the charges not reimbursed by Insurance within 45 days.</i>
			<b>AUTHORIZATION TO RELEASE INFORMATION:</b> I consent to the release of relevant diagnostic, therapy, or other related materials to qualified professional personnel in furtherance of clinical services on behalf of me or my minor being seen; or for whom I am legally responsible, as deemed medically necessary by the attending Speech-Language Pathologist and/or Audiologist at Columbus Speech and Hearing Center.
			<b>ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES</b> (you may refuse to sign this acknowledgement) I have received a copy of this office's <i>Notice of Privacy Practices</i> .

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

### MEDICARE OR MEDICAID AS SECONDARY INSURANCE

I am aware that I am personally responsible for any and all Medicare co-pays, co-insurance, and deductibles for Speech and/or Hearing evaluations or therapy. I am aware that Columbus Speech and Hearing Center cannot bill Medicaid for services rendered on patients over 21 years of age. I agree to pay all monies due to Columbus Speech and Hearing Center at the time services are rendered or upon receipt of an invoice for services rendered by Columbus Speech and Hearing Center.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature/Date

\_\_\_\_\_  
Witness

### FOR OFFICE USE ONLY

We have attempted to obtain written acknowledgement of receipt of our *Notice of Privacy Practices*, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)