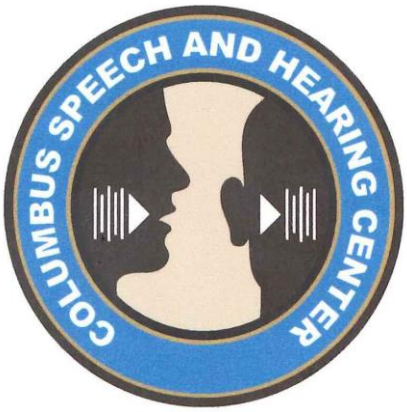


PEDIATRIC INFORMATION PACKET
DIAGNOSTIC EVALUATION

Cover letter
Driving Directions to CSHC

If you intend to seek insurance reimbursement…..*
Patient Intake & Insurance Information*
Pediatric Speech-Language-Hearing Case History Form*
Parent verification of IEP/IFSP status (Pediatrics only)*

To Parents/Guardian:

Your physician has referred your child to Columbus Speech & Hearing Center for a speech/ language/ swallowing or occupational therapy evaluation.

In order to proceed with scheduling an appointment, please complete the enclosed documents and return them to us as soon as possible. When we receive the completed documents, we will contact you to schedule the evaluation appointment.

Please tell us the best way to contact you (check all that apply):

- Phone – give us the number to call _____
- Text – give us the number to text _____
- EMAIL – give us your email address _____

Please tell us when it is best to contact you _____

If you have questions about scheduling, contact Megan Catlin at 706-324-6112, extension 202. Feel free to leave her a voice message if she is not available.

We look forward to seeing you soon.

Enclosed forms for your general information:

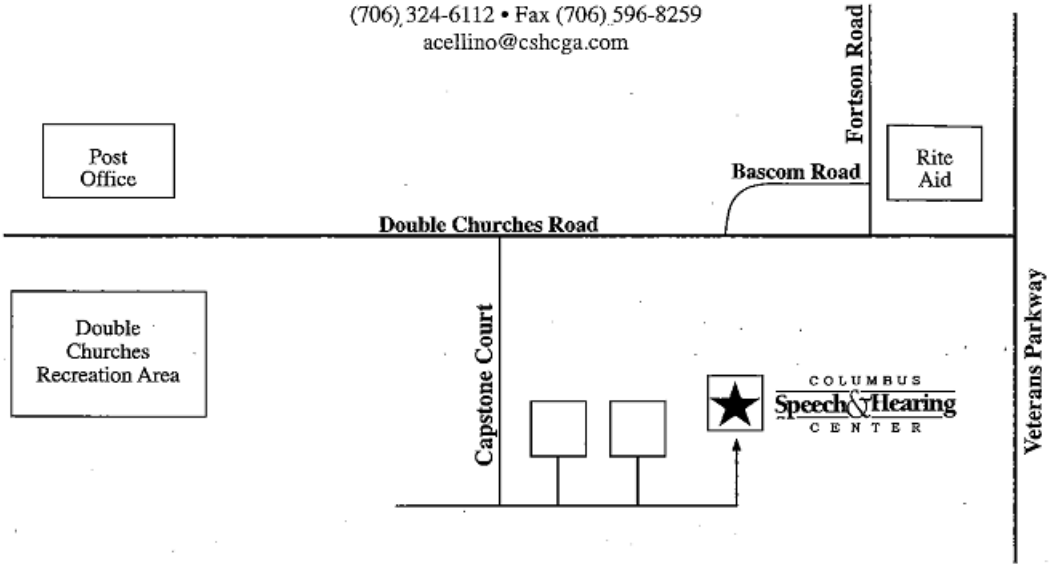
1. *Driving directions to Columbus Speech & Hearing Center*
2. *If You Intend to Seek Insurance Reimbursement*

Materials to return to Columbus Speech & Hearing Center before an initial visit is scheduled:

1. *Case History Form*
2. *Patient Insurance Information*
3. *Parent verification that the child does/does not have a current IEP*
4. *Permission to obtain information form & permission to release information form*

Directions to Columbus Speech & Hearing Center

COLUMBUS
Speech & Hearing
CENTER
2424 Double Churches Road • Columbus, GA 31909
(706) 324-6112 • Fax (706) 596-8259
acellino@cshcga.com



Coming from LaGrange/Atlanta (I-185 South)

- Take Williams Road, Exit 12
- Turn Left onto Williams Road
- Continue on Williams Rd for almost a mile
- Turn Right onto Fortson Road
- Stay on Fortson until you come to traffic light
- Turn Right onto Double Churches Rd
- Pass Palms Apts on Left; CSHC is next entrance on Left

Coming from Ft Benning (I-185 North)

- Take Exit 10 towards US-27/US-80/GA22/Macon/Phenix City, Al
- Keep Right to GA-22 East/US-80E ramp towards US-27 Macon
- Keep Right to take Veterans Pkwy ramp
- Turn Right on Veterans Parkway
- Cross over I-185; Turn Left onto Double Churches Road
- Pass North Lake Center and Palms Apts; take next entrance to Left to CSHC

Coming from East/Midland (JR Allen/US-80)

- Take Exit 4 towards I-185/Atlanta/Ft Benning
- Keep Right to US-27/GA-1/Veterans Pkwy ramp
- Go through traffic light onto Double Churches Road
- Pass North Lake Center and Palms Apts; take next entrance on Left

Coming from Phenix City (US 80 East)

- Take Exit 4 towards US-27/GA-1/Veterans Pkwy/Moon Road/I-185/Ft Benning/Atlanta
- Stay in Right lane and merge onto Veterans Pkwy/US-27 N/GA-1 toward Hamilton
- Turn Right onto Veterans Parkway
- Turn Left onto Double Churches Road
- Pass North Lake Center and the Palms Apts; take next entrance on the Left

IF YOU INTEND TO SEEK INSURANCE REIMBURSEMENT

Columbus Speech & Hearing Center is an approved provider for multiple insurance companies. You should know that insurance companies frequently list speech therapy, audiology, and occupational therapy as reimbursable services, but that is not a guarantee of payment, particularly if the disorder is not due to a "medical" condition. Before your first visit, our staff will contact your insurance company and determine if the diagnostic evaluation is covered, if you have related deductible or co-pay. We will share that information with you before your visit here.

Before your first visit, we need:

1. Your physician to send us a prescription for a speech, language, occupation, and/or hearing evaluation. These scripts are faxed to our office (Fax: 706-596-8259)
2. A copy of your insurance card, front and back. You may provide that at your appointment here.
3. A completed *Patient Intake and Insurance Information* form, which is enclosed

If therapy is needed and you intend to seek insurance reimbursement:

1. Insurance companies typically require a written Diagnostic Evaluation, which we provide with a request for prior authorization of therapy. We notify you of their response before therapy starts.
2. Insurance companies may require periodic (usually on 6 month intervals) re-evaluations with progress reports. These entail additional reports, updated treatment plans, and staff time. Applicable fees are charged to the patient as "Additional services".
3. In general, we cannot negotiate with your insurance company on your behalf. In case of denials, we will provide any information they request, such as diagnostic reports or daily treatment notes. Will share all knowledge we have of what triggered the denial. If it is due to clerical error on our part, we will correct those errors and resubmit the claim. If it is due to the insurance company's coverage restrictions, we cannot negotiate with them on your behalf.
4. You are ultimately responsible for payment n full for any professional services rendered, regardless of your insurance status. Understand that prior authorization for a procedure is not always a guarantee of payment by the insurance company.

PEDIATRIC PATIENT INTAKE AND INSURANCE INFORMATION

	LAST NAME	FIRST NAME	MI	BIRTHDATE
	PRIMARY CARE PHYSICIAN	**SOCIAL SECURITY NUBER**		**SEX**

PARENT INFORMATION

MOTHER'S INFORMATION	FATHER'S INFORMATION
NAME:	NAME:
ADDRESS:	ADDRESS:
OCCUPATION:	OCCUPATION:
EMPLOYER:	EMPLOYER:
BIRTHDATE: SSN	BIRTHDATE: SSN
HOME PHONE: CELL PHONE: WORK PHONE:	HOME PHONE: CELL PHONE: WORK PHONE:
EMAIL:	EMAIL:

INSURANCE IDENTIFYING INFORMATION

	PRIMARY INSURANCE	SECONDARY INSURANCE	TERTIARY INSURANCE
NAME OF INSURANCE			
NAME OF POLICY HOLDER			
RELATIONSHIP TO PATIENT			
POLICY NUMBER			
GROUP NUMBER			
PROVIDER CUSTOMER SERVICE NUMBER			
PLAN TYPE: HMO, POS, PPO			

PATIENT VERIFICATION OF ACCURATE INSURANCE INFORMATION AND RESPONSIBILITY FOR PAYMENT

I understand and agree that I am ultimately responsible for payment in full for any professional services rendered, regardless of my insurance status. The information listed above is true and accurate 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 procedures is not a guarantee of payment. I will promptly notify you of any changes in my health care coverage or the above information.

_____ _____

Patient signature or Parent if patient is a minor Date

_____

Given to Patient/Parent on Date: Received from Patient/Parent on Date:

Columbus Speech & Hearing Center
2424 Double Churches Road
Columbus, Georgia 31909
(706) 324-6112 / (706) 596-8259 fax

PEDIATRIC SPEECH-LANGUAGE-HEARING CASE HISTORY FORM

IDENTIFYING AND FAMILY INFORMATION

Child's Name: _____ Birthdate:_____Sex: 0 M 0 F
Who referred you to CSHC? _____ Doctor's name: _____

Child lives with (check one): ☐ Birth parents ☐ Adoptive parents ☐ One parent ☐ Other: _____
Is there a language other than English spoken in the home? ☐ No ☐ Yes. It is _____

PURPOSE OF THE EVALUATION

1. Please state your main concern and the main problem your child is having: _____
_____
_____
2. Overall, how concerned (worried) are you about your child:
   Parent 1: ☐ Not at all ☐ A little ☐ Moderately ☐ Quite a lot ☐ Extremely
   Parent 2: ☐ Not at all ☐ A little ☐ Moderately ☐ Quite a lot ☐ Extremely
3. Is the problem staying the same, improving, or deteriorating? _____
4. Is there anything that makes the problem worse? _____
5. What questions would you like answered about your child? _____
_____
6. Please describe any previous evaluations or therapy your child has received, related to this problem (psychological, educational, speech-language, occupational therapy, neurological, medical) : _____
_____

BIRTH, DEVELOPMENTAL, AND MEDICAL HISTORY

1. Describe any complications with the pregnancy or during birth (such as infections, high blood pressure, diabetes, bleeding, weight loss, accidents, fever, etc)? _____
2. List any medications during the pregnancy:_____
3. Did you smoke during the pregnancy? ? ☐ No ☐ Yes. Use alcohol or other drugs? ☐ No ☐ Yes
4. Length of the pregnancy?_____ Length of labor? _____Child's birthweight: _____
5. Did the child need any special care during the first few days? ☐ No ☐ Yes. If Yes, describe: _____
6. Has your child ever failed to progress, lost any skills, or gone backwards in development. If Yes, please explain: _
_____
7. As your child was growing up, were you concerned about any of the following? If Yes, explain briefly.
   ____ Early motor development (sitting, walking, running, potty training):_____
   ____ Early language (talking and understanding):_____
   ____ Early social development (eye contact, play, friends): _____
   ____ Early learning (e.g. colors, shapes, drawing):_____
8. Describe any current health problems: _____
9. List any current medications: _____
10. When was your child's hearing last tested and what were the results? _____
11. When was his/her vision last tested and what were the results? _____
12. Please check any areas in which your child has had difficulties:

____fine coordination	____severe illnesses or injuries	____ ear infections	____ eating
____ balance		____ allergies	____ swallowing

13. Has your child been formally diagnosed with any of the following (by a Medical practitioner, Psychologist or other Professional):

____ Attention deficit disorder ____ Autism ____Oppositional defiant disorder
____ Attention deficit/hyperactivity disorder ____Asperger's Synd. ____Dyslexia
____ Learning disability ____ Anxiety disorder ____ Speech or language disorder

14. Does anyone in the family have problems **similar to,** or **the same as**, your child: _____

EDUCATIONAL HISTORY

1. Your child's school: _____ Grade: _____ Teacher: _____
2. Did your child repeat any grades? _____ If Yes, which ones? _____
3. Is your child receiving any extra help in school or in any special classes? Please describe: _____

_____

4. What level best describes your child's general academic progress (Please circle):

Well above Average Above Average Average Below Average Well Below Average

5. Do you believe your child is performing up to his/her potential in school? ☐ No ☐ Yes. ☐ Unsure
6. What are your child's strengths and/or best subjects? _____
7. Please check if there are difficulties in any of the following areas for your child:

____ reading ____ handwriting ____ behavior or motivation ____ social skills
____ spelling ____ copying from the board ____ following directions ____ expressing himself
____ math ____ attention span ____ written expression Clearly

8. Have you ever received special education services or accommodations? Describe: _____

_____

9. Describe your child's attitude towards school: _____

BEHAVIORAL MANAGEMENT

1. Describe your child's personality: _____
2. Describe your child's strengths: _____
3. How do you discipline your child?_____
4. How effective are your discipline methods? _____
5. What frustrates your child most? _____
6. How does your child get along with peers, siblings, or adults? _____
7. Check the following characteristics that describe your child:

____cooperative ____willing to try new activities ____ easily frustrated ____destructive/aggressive
____attentive ____separation difficulties ____ impulsive ____withdrawn
____stubborn ____plays alone for reasonable ____ poor eye contact ____inappropriate behavior
____restless Length of time ____ easily distracted ____self-abusive behavior
____lonely ____intelligent ____ acts young for age ____ independent
____loving ____considerate ____ secure ____ energetic

CURRENT SPEECH-LANGUAGE-HEARING

1. How does your child primarily communicate:

____ body language ____words (Mama, doggy, up) ____ sentences longer than 4 words
____ sounds (vowels, grunting) ____ 2-4 word sentences ____ other:_____

2. Estimate what percentage of the time your child's speech is understood by:

____ Mother ____ Brothers/sisters ____ teachers
____ Father ____ Playmates ____ strangers

In order to help the Speech-Language Pathologist get a complete profile of your child's strengths and weaknesses, please check any of the following areas that you think may apply:

3. **Auditory processing:**

____ does not listen carefully to instructions ____ noise makes it hard to follow instructions
____ sometimes misunderstands what is said ____ says "huh?" or "what?" in response to questions
____ needs extra time to respond to questions ____ does not respond to name when called

4. **Listening:**

____ has trouble paying attention ____ has trouble understanding the meaning of words
____ has trouble following spoken directions ____ has trouble understanding new ideas

____ has trouble understanding what people say
____ has to ask people to repeat what they said
____ has trouble looking at people when talking or listening

5. Speaking:

___ has trouble answering questions
___ has trouble asking for help when needed
___ has trouble describing things to people
___ has trouble telling things in the right order
___ has trouble using complete sentences
___ gets upset when people don't understand
____ has trouble asking questions
____ has trouble expressing thoughts
____ has trouble getting to the point when talking
____ has limited vocabulary, compared with age peers
____ has trouble having a conversation
____ has trouble saying something another way

6. **Social communication:**

___ decreased eye contact when interacting
___ frequent conflicts with peers
____has little interest in social interactions with age peers
____has trouble staying on topic when talking

7. Reading:

____ has trouble sounding out words when reading
____ has trouble understanding what is read
____ has trouble explaining what is read
____ has trouble identifying the main idea
____ has trouble remembering details
____ has trouble following written directions

8. **Writing:**

____ has trouble writing down thoughts
____ has poor grammar when writing
____ has trouble using complete sentences
____ writes short choppy sentences
____ has trouble expanding an answer or providing details
____ has trouble using punctuation meaningfully

9. Sensory sensitivities:

____ reacts emotionally to touch
____ avoids certain common tastes or food smells
____ doesn't seem to notice when face or hands are messy (e.g., with food, drool, mucous)
____ picky eater, especially certain food textures
____ becomes anxious or distressed when feet leave the ground

REPORTS

Do you want a copy of our report sent to your child's doctor? ☐ No ☐ Yes.

To what other professionals or agencies do you want a report sent? _____

_____

Not required, but we would appreciate having a recent picture of your child for our records. If available, please attach here.

Is there sensitive information that you would prefer not to Talk about in front of your child?

If yes, we will discuss these issues while the child waits In another room. Please bring a book or something for Him to do while he waits.

Thank you for taking the time to complete this questionnaire.

Completed by: _____ ***Date*** _____

PARENT VERIFICATION OF IEP STATUS

PATIENT NAME:: _____

DATE OF BIRTH: _____

ACCOUNT NO: _____

To whom it may concern:

This letter is to inform you that my child, _____

(Please check one)

_____ Does have a current Individual Education Plan (IEP) or Individual Service Plan (IFSP),

_____ attends school/preschool/daycare at _____

_____

Where he/she receives speech therapy or occupational therapy services.

_____ Does have a current IEP or IFSP, but it does not include speech, language, or occupational therapy services.

_____ Does not have a current Individual Education Plan (IEP) or Individual Service Plan (IFSP). Columbus Speech and Hearing Center is the only provider of speech, language or occupational therapy services for my child.

_____ _____

PARENT OR GUARDIAN SIGNATURE DATE

NOTE: IF YOU CHILD HAS A CURRENT IEP OR IFSP, PLEASE ATTACH A COPY AND RETURN TO COLUMBUS SPEEH & HEARING CENTER.