Accomplish Speech Therapy, PLLC.

8128 Duck Creek Drive • Raleigh, North Carolina 27616 • Tel 321.287.4684 • Fax 919.981.5771 • Email Lindsey.calhoun.slp@gmail.com
www.accomplishspeechtherapy.net

Dear Parents,

In order to get started with speech therapy services including screening, evaluation, and treatment, we ask that you submit the following initial paperwork to **Accomplish Speech Therapy, PLLC.**

1. A copy of the front and back of the policy holders's insurance card.

2. A copy of the front and back of the patient's insurance card.

3. Signed copies of the following forms:

    - Permission Form
    - Consent of Release of Information
    - HIPPA Authorization
    - Payment Policy & Agreement
    - Cancellation Policy
    - Case History Form

You may fax, mail, or email the completed and signed initial paperwork to Accomplish Speech Therapy,PLLC at:

Accomplish Speech Therapy
8128 Duck Creek Drive
Raleigh, NC 27616
Fax: 919.981.5771
Email: Lindsey.Calhoun.Slp@gmail.com

We look forward to working with you to facilitate and improve your child's speech and language skills. Please do not hesitate to call us at 321.287.4684 if you have any questions about the required forms or about our speech therapy services.

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Permission to Evaluate and/or Provide Therapy

Patient's Name:_____ Date of Birth: _____

Parent Name: _____

Primary Insurance Carrier: _____ Policy #: _____

Please complete the bottom portion of this form to grant permission for Accomplish Speech Therapy, PLLC to evaluate your child's current speech and language skills and provide treatment as needed. Speech-Language evaluations consist of standardized testing, informal and formal observations, and clinician judgment.

I _____, authorize Accomplish Speech Therapy, PLLC to evaluate and
(Parent/Guardian)

provide the recommended speech and language treatment to _____.
(Client)

Therapy/treatment is contingent upon the results of the evaluation and the impending recommendations of the specialized and responsible speech language therapist.

_____ _____ _____
Parent/Guardian Signature Print name of Parent/Guardian

_____
Date

Providing your insurance information (optional) above allows us to verify your benefits so we can share that information with you prior to the start of intervention, if needed.

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Consent for Release of Information

Child's Name: _____ Date of Birth: _____

I, _____ (Parent/Guardian) hereby grant Accomplish Speech Therapy, PLLC to communicate with the following person or agency:

Name of Physician:	**Phone #:**	**Fax #:**
Address:		

Insurance Company/Medicaid:	**Phone #:**	**Fax #:**
Address:		

Other: (If you would like us to communicate with any other professional/person regarding your child's communication skills (i.e., physical therapist, occupational therapist, school speech therapist, etc) please list in the box below.

Name:	**Phone #:**	**Fax #:**
Address:		

_____ **Children's Developmental Service Agency (CDSA)**

Accomplish Speech Therapy, PLLC may discuss and release to the aforementioned person or agency information including but not limited to: evaluation reports, treatment plans, progress note/therapy documentation, previous medical history, as well as necessary verbal communication pertaining to the child. This information will be use for diagnostic and treatment planning purposes **ONLY**. It is my understanding that this information will not be shared with any other entity without my prior knowledge. I further acknowledge that the use of this information is to ensure the best quality of care possible for my child.

_____ _____

Parent/Guardian Name Date

_____

Parent/Guardian Signature

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Parent Notification of Privacy Policies (HIPPAA Authorization)

Child's Name: _____ Date of Birth: _____

Address: _____

Our commitment to Patient Privacy

Accomplish Speech Therapy, PLLC is dedicated to ensuring the privacy of your child's speech and/or language evaluation finding and treatment. In serving our patients, we create records in order to have accurate documents to ensure the appropriateness, efficiency and efficacy of treatment services. Federal law requires us to protect any and all personally identifying information on your child. The notice below discloses our policies regarding the storage, use and sharing of confidential patient information. **PLEASE REVIEW TH E NOTICE CAREFULLY.** I authorize use or disclosure of protected health information about my child as described below.

1. Accomplish Speech Therapy, PLLC and its employees are authorized to use or disclose health information that is pertinent or required for Speech-Language Therapy purposes.

2. Accomplish Speech Therapy, PLLC is authorized to disclose health information considered pertinent to Speech-Language Therapy to the patients' insurance company(s) or referring physicians for the purposes to requesting doctor's orders, authorization for services, or to obtain reimbursement for services rendered. Information may be sent via first class mail or fax with procedures to limit the likelihood of unauthorized access. The date will be documented by the responsible office personnel.

3. I understand that Accomplish Speech Therapy, PLLC will be disclosing protected health information to patients' physician, teacher, and social worker (where necessary) and also understand that the information used or disclosed may be subject to re-disclosure by the individual or facility receiving the information.

4. I, the parent/guardian, may revoke this authorization by notifying LINDSEY CALHOUN AND OR ACCOMPLISH SPEECH THERAPY, PLLC in writing of my desire to revoke it. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

5. This authorization expires when a patient is discharged by Accomplish Speech Therapy, PLLC or receives written desire to revoke it.

6. Confidential patient information will be stored in a secure location. All computers and PDA's containing confidential information will be password protected.

I have read and understand the privacy policies disclosed in this notice.

_____ _____

Parent/Guardian Signature Date of Signature

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DEMOGRAPHIC/IDENTIFYING INFORMATION

Date: _____

Name of person completing form: _____ Relationship to Child: _____

Child's Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Gender: _____

Parent's/Caregivers Names: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Preferred Method of Contact: ☐ Cell Phone ☐ Home Phone ☐ Email Email Address: _____

Is there a language other than English spoken in the home? ☐ Yes ☐ No

If Yes, which one? _____

Does the child speak the language? ☐ Yes ☐ No

Does the child understand the language? ☐ Yes ☐ No

Who speaks the language? _____

Which language does the child prefer to speak at home? _____

Child's Physician/Pediatrician: _____ Phone: _____

Medical Diagnosis: _____

Other Physicians/Specialists/Professionals working with your child

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

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FAMILY HISTORY

Father's Name: _____ Age: _____

Education (last grade attended): _____

Present Occupation: _____

History of Speech/Language Delays? ☐ Yes ☐ No

If yes, what kind of delays: _____

_____

Mother's Name: _____ Age: _____

Education (last grade attended): _____

Present Occupation: _____

History of Speech/Language Delays? ☐ Yes ☐ No

If yes, what kind of delays: _____

_____

Other Children in the family:

Name	Age	Sex	Grade	Speech/Hearing Difficulties

BIRTH HISTORY

Delivery: Normal Instrument Breech Caesarian

Duration of labor: _____ Term: _____

Birth weight: _____ Age of Mother at Birth: _____

Unusual condition at or immediately after birth: _____

Developmental Milestones: (Please check which one applies): ☐ Achieved within normal limits ☐ Delayed

List specific delay(s): _____

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If adopted at what age was your child adopted:
Please include any information pertinent to the adoption. _____

MEDICAL HISTORY

Has your child ever had any of the following? If yes, when (date)?

- ☐ Adenoidectomy _____
- ☐ Allergies _____
- ☐ Asthma _____
- ☐ Chicken Pox _____
- ☐ Ear Infections _____
  How often? _____
- ☐ Ear Tubes _____
- ☐ Rheumatic Fever _____
- ☐ Hay Fever _____
- ☐ Encephalitis _____
- ☐ Influenza/Flu_____
- ☐ Head Injury _____
- ☐ High Fevers _____
- ☐ Measles _____
- ☐ Meningitis _____
- ☐ Tonsillitis _____
- ☐ Whooping Cough _____
- ☐ Other _____
- ☐ Seizures _____
- ☐ Sinusitis _____
- ☐ Sleeping Difficulties _____
- ☐ Colds _____
- ☐ Mumps _____
- ☐ Tonsillectomy _____
- ☐ Scarlet Fever _____
- ☐ Pneumonia _____

Any Surgeries? ☐ Yes ☐ No

If Yes, please list: _____

Any Injuries? ☐ Yes ☐ No

If Yes, please list: _____

Vision Impairments or Concerns? ☐ Yes ☐ No

If yes, please explain: _____

Does your child currently take any medications? ☐ Yes ☐ No

If yes, please list the medication and for what condition it is taken.

_____

_____

_____

_____

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SPEECH- LANGUAGE- HEARING

Is your child nonverbal? ☐ Yes ☐ No

If your child is nonverbal, describe how your child communicates with you, please give examples. _____

Age first word spoken: _____ Age 2-3 word combinations spoken: _____

Age first sentences spoken: _____ Typical length of utterances: _____

Rate of speech development: ☐ Fast ☐ Average ☐ Slow

Describe his/her speech at the present time: _____

Is your child speech easily understood by the listener?
_____

When did you first become concerned about his/her speech? _____

Intelligibility of child's speech: (Check any that apply)

☐ Easily understood ☐ Understood if listener knows topic ☐ Words understood now and then ☐ Completely unintelligible

Has your child ever had a speech evaluation/screening? ☐ Yes ☐ No

If yes, where and when? _____

What were you told? _____

Has your child ever had speech therapy? ☐ Yes ☐ No

If yes, where and when? _____

Has your child ever received any other evaluation or therapy (physical, occupational, counseling)? ☐ Yes ☐ No

If yes, please describe _____

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SPEECH- LANGUAGE- HEARING CONT.

Has your child experienced frequent ear infections? ☐ Yes ☐ No

If yes, how frequent? _____ what was done? _____

Date of last hearing screening? _____

SCHOOL HISTORY

If your child is in school, please answer the following:

Name of Preschool/school: _____ Grade: _____

Teacher's Name: _____

Has your child repeated a grade? ☐ Yes ☐ No

If yes, what grade and why? _____

What are your child's strengths and/or best subjects? _____

Is your child having difficulty with any subjects? _____

Is your child receiving any help in any subjects? _____

Does your child have an IEP? ☐ Yes ☐ No

What are his/her IEP goals? _____

Does your child receive any special services? Please list and include the frequency of each (i.e., speech therapy, occupational therapy, physical therapy): _____

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INSURANCE INFORMATION

**Please provide a copy of Ins. Card front/back

Insurance Company/Carrier___ _____ Insured's Name: _____

Insured's Date of Birth: _____ Member ID #: _____

Insurance Address: _____ City: _____ State: _____ Zip:_____

Insurance Phone #: _____ Policy/Group #: _____ Medicaid #: _____

Billing Preference: ☐ Paper Mail ☐ Email Email Address: _____ ☐ Paypal/Credit

Physician Name: _____ Practice Name: _____

Physician Phone: _____ Physician Fax: _____

ADDITIONAL COMMENTS

_____

_____

_____

_____

_____

_____

_____

_____