Patient Information

Patient Name:		Sex: ☐ Male ☐ Female	DOB:
Address:		Parent/Guardian SS#	
City:	State:	Zip:	County:
Guardian Name: Cell Number:		Guardian Name: Cell Number:	
Home Number:		Email:	
Address:			
City:		State:	Zip:
Patient Covered By (check all that apply): ☐ Primary Insurance ☐ Secondary Insurance ☐ Medicaid ☐ Babies Can't Wait			
Diagnosis: _____ Diagnosed by: _____ Date: _____			
Medications:			
Allergies:			

Pediatrician Information

Pediatrician Name:		Name of Practice:	
Address:			
City:	State:	Zip:	County:
Phone Number:		Fax Number:	

Primary Insurance

Policy Holder:	Relationship to Patient:		DOB:
Name of Insurance:	Plan Name:		
Type: HMO PPO EPO Other:	Group #:	Member #:	
Claims Address:			
City:	State:	Zip:	Phone:

Medicaid / Amerigroup / Peachstate Health Plan

Policy Holder:	Effective Date (if known):
Date of Birth:	Medicaid #:

Please copy both sides of your insurance card and your child's Medicaid card or IFSP.
If you have Secondary Insurance, please write that on a separate sheet and copy both sides of the card.
Failure to complete this sheet in its entirety will nullify any agreement allowing file your claims.
THIS WILL RESULT IN THE GUARANTOR BEARING ALL FINANCIAL RESPONSILBILITY FOR DIRECT PAYMENT FOR ALL SERVICES RENDERED ON THIS ACCOUNT!

11785 Northfall Lane Suite 502
Alpharetta, GA 30009
Phone: (770) 569-2274 Fax: (770) 569-7432
Email: chatterboxinc@me.com

Pediatric Case History Form

Today's date: ___/____/_____
Person completing this form: _____
Relationship to child: _____

I. MEDICAL HISTORY

1. This child is our/my: (circle one)
☐ Biological Adopted ☐ Foster child ☐
2. Mother has had _____ pregnancies. This child was the _____ pregnancy.
3. Check any of the following that the mother experienced during pregnancy with this child and provide the month.

X	Description	Month	X	Description	Month
	Bleeding			Virus Infection	
	Swelling			Measles/ Rubella	
	High Blood Pressure			Diabetes	
	Low Blood Pressure			Heart condition	
	Convulsions			Asthma	
	Excessive weight loss/gain			Thyroid Condition	
	Rh Negative Blood			Accidents	
	Toxemia			Kidney Disease	
	Medications (what kind?)			Surgeries	
	Anesthetics			X-Rays	
	Other			Other	

4. What was the length of this pregnancy? _____
5. What was the length of the hard labor? _____
6. What was the type of delivery: (check one)
_____ Vertex (head presentation)
_____ Breech
_____ Caesarian
_____ Dry
_____ Other _____
7. Were there any unusual problems at birth? Yes or No?
If so, describe _____
_____
_____
8. What was this child's birth weight? _____

9. Check any of the following that occurred during the first two weeks of infant life:

Child's Name: _____

X	Description	X	Description
	Jaundice		Transfusion
	Blueness		Oxygen
	Difficulty Breathing		Feeding difficulty
	Convulsions		Intravenous or intramuscular fluids
	Incubator or isolate		Cry (strong, weak, high)
	Infection		Hemorrhage
	Tube Fed		Other:

10. How long did this child remain in the hospital following birth? _____

11. Is there any other information about the mother or baby, which may help us evaluate this child? _____

_____

12. At what age did the following occur:

Description	Age	Description	Age
Crawl		Sat Up	
Stood		Walked	
Fed Self		Dress Self	
Toileted		Babble	
Single Word		Combined Words	

13. Is child well coordinated or clumsy? _____

14. Does child lose balance or fall easily? _____

II. SIGNIFICANT HISTORY

1. Check any of the following conditions or surgeries that this child has experienced:

X	Description	Age	X	Description	Age
	Whooping Cough			Adenoidectomy	
	Mumps			Allergies	
	Scarlet Fever			Epilepsy	
	Measles			Encephalitis	
	Pneumonia			Tonsilitis	
	Diptheria			Chronic colds	
	Croup			Head Injuries	
	Influenza			Mastoidectomy	
	Headaches			Asthma	
	Chicken Pox			Sinus	
	Dental Problems			Meningitis	
	Ear Infections			Draining Ears	
	P.E. Tube Insertion			Tonsillectomy	
	Other:			Other:	

2. Describe any other operations your child has had. _____

_____

3. Describe any other serious illnesses your child has had. _____

_____

_____

4. Is child presently taking any medications? Yes or No?
What medication(s)? _____

5. Has child had any other therapies?

If so, what kind_____

_____

6. When was the most recent hearing test? _____

Results? _____

7. When was the most recent vision test? _____

Results? _____

III. FAMILY HISTORY

1. Parents:

	Mother	Father
Birth Date		
Highest Grade Completed		
Occupation		
Place of Employment		

2. Brothers and Sisters:

Name	Age	Sex	Speech/Hearing/Medical Problems

VI. ASSOCIATED SERVICES

1. Cognitive Testing

a. Date _____ where _____

b. Results _____

_____

2. Neurological Testing

a. Date _____ where _____

b. Results _____

_____

3. Physical Therapy and/or Evaluation

a. Date _____ where _____

b. Results _____

_____

4. Occupational Therapy and/or Evaluation

a. Date _____ where _____

b. Results _____

_____

IV. Please add any information or comments that you think might be helpful.

_____

_____

_____

_____

_____

_____

11785 Northfall Lane Suite 502
Alpharetta, GA 30009
Phone: (770) 569-2274 Fax: (770) 569-7432
Email: chatterboxinc@me.com

Medical Records Release

I, _____, authorize Chatterbox Inc. to
(Parent/ Guardian)
release/ obtain all medical records for:

_____ _____

(Child's name) (Child's Date of Birth)

Please send documentation to :

Chatterbox Inc.
11785 Northfall Lane Suite 502
Alpharetta, GA 30009

OR

Fax: (770) 569-7432

Sincerely,

_____ _____

Signature Date

11785 Northfall Lane Suite 502
Alpharetta, GA 30009
Phone: (770) 569-2274 Fax: (770) 569-7432
Email: chatterboxinc@me.com

ASSIGNMENT OF INSURANCE BENEFITS

I, _____, authorize Chatterbox Inc. to
(Parent/ Guardian)
release any information regarding _____, to
(Child's name)
his/ her insurance company/ payor. Only information needed for coverage of therapy will be released. I authorize Chatterbox Inc. to bill for and receive payment for therapy services from his/ her insurance company/ payor.

_____ _____
Signature Date

FINANCIAL POLICY (please take time to read)

Insurance

- Insurance will be billed at the usual and customary rate.
- We will need a copy of your valid insurance card (front and back).
- We are in network with Blue Cross Blue Shield, Medicaid and Peach State. We still accept all insurance companies as long as you have out of network benefits.
- If you do not have insurance or choose not to use it, you can pay the out of pocket rate or $140.00
- Please note that insurance is an agreement between you and your insurance company, benefits and payment are not always covered and payment will ultimately rest with the guardian.
- Co Pay – you are responsible for any co pay at time of visit
- Co-insurance – you will be invoiced for your co insurance once we receive the EOB
- Deductible – you will be responsible for payment of your deductible, this amount will be stated on your EOB and invoiced once received.
- Please notify us immediately if there is a change in coverage.

_____
(Initials)

Claims Submittal

- We will submit claims on your behalf if requested. Once a copy of the insurance card is received we can submit claims, an EOB is then received and payment will be determined.

_____
(Initials)

No Pay

- Once you receive an invoice, payment is due within 15 days.
- If payment is not received within 15 days a 10% interest charge will be added.
- After three failed attempts to collect outstanding balance, your balance may be sent to a collection agency.
- In certain cases a payment plan may be setup. Please ask if you qualify.

_____
(Initials)

Rates

Out of pocket rate is $ 140.00
Out of pocket rate for an evaluation is $300

Meeting rate is $140.00 per hour.

_____
(Initials)

Cancellation Policy

Therapy must be cancelled at least 24 hours prior to the session. We will make exception for sudden illness, injury or family emergencies, but we still require notification prior to therapy. **Any missed appointment or no shows will be charged $50.** If a patient continues to miss appointments we may discontinue services and put you on a waiting list to get back in. It is important for everybody to stay in contact.

_____
(Initials)

Person who signs below is responsible for payment.

Please return completed intake to :
Chatterboxinc@me.com and angieb.chatterbox@gmail.com

_____	_____	_____
Signature of Parent/Responsible Party	Print Patient Name	Date

Chatterbox Inc.

Notice of privacy practices
As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVUALLY IDENTIFIABLE HEALTH INFORMATION

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

How we may use and disclose your IIHI
Your privacy rights in your IIHI
Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. You may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Chatterbox Inc.
4825 Chase Lane
Cumming, GA 30040

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS:

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:
   i. Reporting child abuse or neglect
   ii. Preventing or controlling injury or disability
   iii. Notifying individuals if a product or device they may be using has been recalled
   iv. Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of a patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute. Our relationship with you does not confer any doctor/patient or similar privilege against disclosure.
4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:
   i. Regarding a crime violation in certain situations, if we are unable to obtain the person's agreement
   ii. Concerning a death we believe has resulted from criminal conduct
   iii. Regarding criminal conduct at our office or at the individuals residence during the treatment
   iv. In response to a warrant, summons, court order, subpoena or similar legal process
   v. To identify/locate a suspect, material witness, fugitive or missing person
   vi. In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)
5. Deceased Patients. Our practice may release IIHI if requested by a government official.
6. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (ii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the researcher only relates to decedents and the researchers agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.
7. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

8. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities).
9. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
10. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals
11. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

12. Parent or legal guardian or other disclosed person. We may disclose information to any other parent or legal guardian of the patient, as to the following person(s) who you are specifically designating to receive this information:

_____

_____

_____

13. Any other person or organization who you may authorize us to provide information to, if that authorization is in writing and is dated and signed by you.
14. Your primary care and/or your referring physician.

The following categories describe the different ways in which we may use and disclose your IIHI

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have additional tests such as MRI, and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write an evaluation or we may disclose your IIHI to an Occupational Therapist (OT), Speech Language Pathologist (SLP), or Physical Therapist (PT) if requested. Many of the people who work for our practice – including, but not limited to, our OTs, PTs, and SLPs – may use or disclose your IIHI in order to treat you or to assist others in your treatment, Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.
2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.
3. Health Business Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.
4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.
5. Health-Related benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
6. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter be with the child during treatment. In this example, the babysitter may have access to this child's information.
7. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Chatterbox Inc., 4825 Chase Lane, Cumming, GA 30040,** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to Therapy, Inc. contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Chatterbox Inc., 4825 Chase Lane, Cumming, GA 30040**. Your request must describe in a clear and concise fashion:
   The information you wish restricted:
   Whether you are requesting to limit our practice's use, disclosure or both; and to whom you want the limits to apply.
3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Chatterbox Inc., 4825 Chase Lane, Cumming, GA 30040**, in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request in writing and submitted to contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Chatterbox Inc., 4825 Chase Lane, Cumming, GA 30040** You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, an OT sharing information with another OT in the practice; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Chatterbox Inc., 4825 Chase Lane, Cumming, GA 30040**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before June 25, 2007. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice or privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Zane Krog. In order to request a type of confidential communication, you must make a written request to **Chatterbox Inc., 4825 Chase Lane, Cumming, GA 30040**
7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Zane Krog. In order to request a type of confidential communication, you must make a written request to **Chatterbox Inc., 4825 Chase Lane, Cumming, GA 30040**. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice of our health information privacy policies, please contact Zane Krog. In order to request a type of confidential communication, you must make a written request to **Chatterbox Inc., 4825 Chase Lane, Cumming, GA 30040**

Effective Date of this notice: June 25, 2007

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services Office of Civil Rights 200 Independence Avenue, S.W. Washington, D.C. 20201 877-696-6775 (toll-free)

Receipt of Privacy Practices

I _____ have received a copy of Chatterbox Inc.'s Notice of Privacy Practices with an effective date of January 1,

_____ _____

Name of Patient Signature of Parent/ Responsible party

_____

Date

Credit Card Processing Authorization Form

Child's Name: _____ Date of Birth:_____

Payment Information

By signing below, you confirm you fully understand the health insurance policies and reimbursement issues are between you and your health insurance company, that all services rendered to your child are charged directly to you if not covered or paid by your insurance company, and that you are personally responsible for payment to Chatterbox, Inc. and that this responsibility is not related to potential health insurance coverage or reimbursement.

The undersigned authorizes Chatterbox, Inc. to make the following charges to their credit card for payment for speech therapy, occupational therapy and/or physical therapy services rendered and /or associated expenses.

TYPE OF CARD:

☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMEX ☐ HSA/FLEX SPENDING

NAME ON CARD (as it appears on card): _____

CARD NUMBER: _____

EXPIRATION DATE: _____ 3 DIGIT CODE: _____

BILLING ADDRESS: _____

PHONE NUMBER: _____

EMAIL ADDRESS (for credit card receipts): _____

DATE: _____

This information must match the card, or it will not process. You must notify our office as soon as possible if any of this information changes. This agreement will remain in effect and your card may be charged monthly, until this agreement is cancelled in writing.

Signature of Cardholder: _____ Date _____