Bosque Valley Children's Services

2124 N. 25th St., Waco, Texas 76708

Phone: 254-235-2430 Fax: 254-235-2434

"Where our children's future begins..."

Sterling Speech & Language Services P.O. Box 21491, Waco, Texas 76708

Referral Information: [ ] ST [ ] Coun [ ] PT [ ] OT

Date: _____ Referred by: _____

Person Providing Info: _____ Intake by : _____

Client Name: _____ DOB _____

SS# _____-_____-_____ M / F Parent/Guardian Name: _____

Address: _____ Primary Ph #: _____

_____ Alternate Ph #: _____

Diagnosis: _____ Date of Onset: _____

ICD-9 Code: _____ Current therapy? Y / N If yes, explain, _____

_____.

Treatment site requested? [ ] Home [ ] HDC _____ [ ] Clinic

Physician: _____ Ph # _____

Address: _____ Fax # _____

NPI: _____ TPI: _____

[ ] Medicaid is primary Medicaid# _____ Elig Dates: _____

[ ] Insurance is primary Insurance Co: _____

Insured: _____ Insur. Co. Ph# _____

Relationship to client: _____ Address: _____

Policy # _____ Group# _____ _____

Effective Date _____ Renewal Date _____

Insurance continued: Electronic Payer # _____

Insured SSN: _____-____-_____ DOB _____ ID # _____

Employer_____ Ph# _____

Deductible _____ Co-Pay or % of Patient Responsibility _____

Has deductible been met? Y / N In/Out of Network? _____

Are there any exclusions for therapies? Y / N If yes, explain: _____

_____

# of visits: _____ [ ] not limited

Diagnosis; _____ Is diagnosis covered? Y / N Code: _____

[ ] Medicaid is secondary Medicaid# _____ Elig Dates: _____

[ ] Insurance is secondary Insurance Co: _____

Insured: _____ Insur. Co. Ph# _____

Relationship to client: _____ Address: _____

Policy #_____ Group# _____ _____

Effective Date _____ Renewal Date _____

Electronic Payer # _____

Insured SSN: _____-____-_____ DOB _____ ID # _____

Employer_____ Ph# _____

Deductible _____ Co-Pay or % of Patient Responsibility _____

Has deductible been met? Y / N In/Out of Network? _____

Previous Therapy? Y / N If yes, notes: _____

_____

_____

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Consent for Evaluation and Release of Records; Notification of Procedures

[ ] Speech/Language Therapy [ ] Counseling [ ] Physical Therapy [ ] Occupational Therapy

Child's Name: _____

Please initial to the left of each item:

_____ I (parent/ patient representative as noted below) have been informed that each practitioner at Bosque Valley Children's Services is licensed and certified to provide therapeutic services according to the Plan of Care established by the therapist. I accept treatment from the practitioner(s) of Bosque Valley Children's Services on behalf of my child. I can call Bosque Valley Children's Services at 254-235-2430 in regard to my child's therapy.

_____ It is the policy of Bosque Valley Children's Services to protect all clinical records against loss, defacement, tampering or use by unauthorized persons. I authorize Bosque Valley Children's Services and its practitioners to release medical information to my physician, the facility of my choice, pay source or accrediting/regulatory/consulting agencies as appropriate. I authorize the release of the Plan of Care and Discharge Summary upon transfer to another health care provider.

_____ In the interest of parent convenience, portions of my child's information may also be relayed to an independent speech, counseling or physical therapy company if the parent/guardian or physician requested interdisciplinary treatment in order to communicate with me regarding services for my child.

_____ I authorize Bosque Valley Children's Services to obtain private medical and/or educational records as required to facilitate the care of my child. Such records may be obtained from my child's physician, counselor, teacher, school/day care, EOAC Head Start facility or other agency deemed to have pertinent information in regard to my child's therapy. I understand that I may revoke this authorization at any time by writing a letter so stating to Bosque Valley Children's Services (with the exception to action that has already been taken in reliance of this authorization.)

_____ I give permission to Bosque Valley Children's Services and its practitioners to allow my child to use clinic equipment, toys, games and/or other manipulatives in the course of therapy and/or reinforcement of goal attainment. I understand that these devices or tools are for the purpose of therapy and/or the reinforcement of learning. As the parent/guardian I do hereby fully and finally release Bosque Valley Children's Services, its practitioners, employees, or student interns and volunteers who are under the supervision or direction of a therapist from any and all claims due to loss or injury that my child might sustain while using these devices/tools. I acknowledge the potential risks; however I feel the benefits to my child are greater than risks assumed.

_____ I do OR _____ do not give Bosque Valley Children's Services permission to use my child's photograph. This includes clinic or public viewing, posting on the company's website, etc.

_____ I understand that the recommendations regarding treatment, the expected benefits or goals of the treatment and the frequency of services will be explained to me and my questions regarding the Plan of Care will be answered after the initial evaluation. I understand that these recommendations may change according to need as the treatment progresses.

_____ I understand I have the right and the responsibility to be involved in the care of my child and that I will be informed as to the nature and the purpose of any technical procedure.

_____ I have received a copy and an explanation of my rights under HIPAA and I have received the Notice of Privacy Practices designed to protect information regarding my child. I do consent to Bosque Valley Children's Services use and disclosure of protected health information for payment, treatment and health care agencies operations.

_____ I have been notified of my right to voice a complaint and understand that I may first file a complaint with the company administrator or designee at 254-235-2430. I can also contact the Texas Dept. of Health, 1100 W. 49th St, Austin, Texas 78756; or by calling 1-888-973-0022 in the event That I need information or if a complaint is not resolved. The phone line is open 24 hours a day, 7 days a week. This includes a complaint regarding advance directives. Complaints regarding Utilization review or HMO services can be made directly to the Texas Dept. of Health Insurance, P.O.Box 149091, Austin, Texas, 78714; or by calling 1-800-252-3439

_____ ____/____/_____

Patient/Parent or Authorized Representative Date

Patient unable to sign due to: _____

_____ ____/____/_____

BVCS Staff or designated agency representative Date

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CASE HISTORY FORM

Patient's name:_____ DOB _____/_____/_____

Age: _____ M / F Address: _____

Parent/Guardian:_____ Address if different _____

Home Ph# _____ Work/Cell# _____ _____

Please answer the following questions. If YES, please explain briefly:

Y / N Were there complications during the pregnancy or birth of your child?_____

_____

Y / N Are there any concerns about delays in speech or language development? _____

_____

Y / N Are there any concerns about fine/small motor development (such as writing, etc.)? _____

_____

Y / N Are there any concerns about delays in gross/large motor skills (such as walking, etc.)? _____

_____

Y / N Were there other developmental milestones not reached at an appropriate age? _____

_____

Y / N Has your child had any major accidents or illnesses requiring a hospital stay or surgery?_____

_____

Y / N Has your child been diagnosed with any chronic or ongoing conditions (ex. diabetes, hearing or vision problems, ADD/ADHD)? _____

_____

Other comments: _____

_____

Doctor Name	Address	Phone#

Medications	Reasons	Length of Use	Side Effects

Please provide the following information if you child has had previous evaluation (ex. educational, medical):

Type of Eval.:_____ Performed by:_____ Date of Eval.: ____/____/____

Type of Eval.:_____ Performed by:_____ Date of Eval.: ____/____/____

SOCIAL HISTORY

- How well does your child get along with others? _____
- How does your child spend his/her free time?_____
- Are there any significant behaviors that you are concerned with at this time? _____
  _____
- Have there been any major or significant changes in your child's environment? _____
  _____

SCHOOL HISTORY

- Does your child attend school or daycare? _____ May we contact them? Y / N
  Phone # _____ Address _____
- Please explain any concerns you have about your child's learning: _____
  _____

What would you like to see your child accomplish in therapy? _____

_____

I understand that this form and the information therein will be used by any and all contractors of Bosque Valley Children's Services who will provide services to my child.

Signed:_____ Date ____/____/____ Relationship to Patient _____