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 [ ] 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 [ ] Physical Therapy [ ] Occupational Therapy

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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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Payment / Insurance Information: Patient Name : ______________________________________

I UNDERSTAND THE FOLLOWING:

- This authorization will be used by all Bosque Valley Children's Services (hereafter BVCS) contractors.
- Payment or insurance co-payment is due at the time of service. BVCS does not carry outstanding balances on account.
- If my child is covered by a health insurance I further acknowledge that:
  - I agree to pay BVCS for services provided for my child. I understand that BVCS may be an out of network provider and I acknowledge responsibility for any and all balances by my insurance.
  - I am responsible for contacting my insurance company to verify covered services and to have benefits fully explained to me. I do not hold BVCS or its affiliates responsible for any incorrect or omitted information or changes in my coverage.
  - I agree that I am responsible for the contract between the insurance company and myself. I am responsible for informing BVCS if my health insurance/method of payment changes within 7 days of the change.
  - I understand that my benefits have been obtained by phone or fax as stated by the insurance company to BVCS and are not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible to BVCS for the charges incurred.
  - I must meet the yearly deductible as stated by my insurance plan
  - If a claim is denied for BVCS services which have been submitted on my behalf, I hereby elect not to appeal the denial myself, but I do authorize BVCS to resubmit the claim oro me and represent me in any negotiations.
  - I will pay for any service charges not reimbursed by my insurance company when the BVCS bill is received.
  - If the insurance plan refuses coverage, I am responsible for BVCS charges.

Financial Authorization: I authorize benefits to be made on my behalf,

Bill Medicaid: ________% Medicaid # ____________________

Bill Primary Insurance __________ % Company: __________________________

ID# ___________________ Ph# ___________________________

Bill Secondary Insurance _________ % Company: __________________________

ID# _____________ Ph# ___________________________

Client co-pay: ___________________ per visit Client self-pay: ___________________

Signature of Insured ____ Date _____ / _____ / 201___

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Parent Consent to Release Authorization from Previous Agency to

Sterling Speech & Language Services, LLC dba Bosque Valley Children's Services

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Please discharge the current PAN authorization for:

____, effective _________/__________/ 201____.

Medicaid# or ID# ______________________________________

The last date of service provided by ____, the previous agency, was __________/ ___________/ 201___ (if known).

____ Date _________/ _________/201___

Client / Parent / Guardian

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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 Was there a history of use of alcohol, tobacco or drugs by the biological mother during pregnancy? ___

____

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)? ______________________

____

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 ___________

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1. Language(s) spoken in the home: ________________
2. Does the child speak the language? Yes / No (circle one)
3. Does the child understand the language? Yes / No (circle one)
4. What language does the child prefer to speak? ____________
5. Any family members or relatives who have or had any speech, language, or hearing issues or therapy? Yes / No (circle one)
   If yes, please specify: ______________________________

Current Speech-Language-Hearing

(Check all that apply)

Does your child...

- ☐ Choke on food or liquids?
- ☐ Currently put toys/objects in his/her mouth?
- ☐ Brush his/her teeth and/or allow brushing?

Does your child...

- ☐ Repeat sounds, words or phrases over and over?
- ☐ Understand what you are saying?
- ☐ Retrieve/ point to common objects upon request (ball, cup, shoes)?
- ☐ Follow simple directions ("Shut the door" or "Get your shoes")?
- ☐ Respond correctly to yes/no questions?
- ☐ Respond correctly to who/what/where/when/why questions?

Your child currently communicates using...

- ☐ Gestures.
- ☐ Body language.
- ☐ Sounds (vowel, grunting).
- ☐ Words (shoe, doggy, up).
- ☐ 2 to 4 word sentences.
- ☐ Sentences longer than four words.
- ☐ Other: ____________________________

Behavioral Characteristics:

- ☐ Cooperative
- ☐ Attentive
- ☐ Willing to try new activities
- ☐ Plays alone for reasonable length of time
- ☐ Separation difficulties
- ☐ Easily frustrated/ impulsive
- ☐ Stubborn
- ☐ Restless
- ☐ Poor eye contact
- ☐ Easily distracted/ short attention
- ☐ Destructive/ aggressive
- ☐ Withdrawn
- ☐ Inappropriate behavior
- ☐ Self-abusive behavior

Has your child...

1. Has your child had ear infections? YES/NO
2. If yes, were tubes placed? YES / NO

Right ear ___ Left ear ___ Both ears ___