

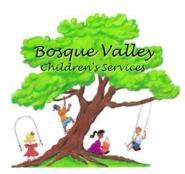
2124 N. 25th St., Waco, Texas 76708 Phone: 254-235-2430 Fax: 254-235-2434 "Where our children's future begins..."

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

Referral Information:	[] Speech Therapy	[] Occupational Therapy	
Date: Referred by:			
Person Providing Info:		Intake by:	
	Patient Inf	formation	
Client name:		Date of Birth:	
SS#	M / F Par	rent/Guardian Name:	
Address:		Primary Ph #:	
		Alternate Ph #:	
Email:			
Current Therapy? Y / N	If yes, explain,		
Previous Therapy? Y / I	N If yes, notes:		
Therapy location reques	sted: [] Clinic [] Home	e [] Daycare/Head Start:	
	Physician Ir	nformation	
Physician:		Ph #	
Address:		Fax #	

Primary Insurance Information

[] Medicaid is primary Medicaid #:	Effective Date:				
	[] BCBS Star [] United Star [] Traditional				
[] Commercial insurance is primary	- OR				
Insurance Co:					
Insured:	Insur. Co. Ph#				
Relationship to client:	Address:				
Policy #	Group#				
Effective Date	Renewal Date:				
Insured SSN:	Date of Birth:				
Employer	Ph#				
Secondary Insurance Information					
[] Medicaid is secondary Medicaid#:	Effective Date:				
Please select Medicaid Provider: [] Amerigroup [] Superior [] Rightcare [] BCBS Star [] United Star [] Tradit					
[] Commercial insurance is secondary	OR				
Insurance Co:					
Insured:	Insur. Co. Ph#				
Relationship to client:					
Policy #					
Effective Date					
Insured SSN:					
Employer	Ph#				



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

Consent for Evaluation and Release of Records; Notification of Procedures [] Occupational Therapy [] Speech/Language 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 my 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/daycare, 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.)

BVCS Consent form 2011 Page 1 of 2

I give permission to Bosque Valley Children's Service Indicate the Child to use clinic equipment, toys, games and/or other and/or reinforcement of goal attainment. I understand the curpose of therapy and/or the reinforcement of learning and finally release Bosque Valley Children's Services, interns and volunteers who are under the supervision or claims due to loss or injury that my child might sustain acknowledge the potential risks; however, I feel the benessumed.	manipulatives in the course of therapy nat these devices or tools are for the . As the parent/guardian I do herby fully its practitioners, employees, or student direction of a therapist from any and all while using these devices/tools. I
I do OR do not give Bosque Valley Children's photograph. This includes clinic or public viewing, post	
I understand that the recommendations regarding to he treatment and the frequency of services will be explain he Plan of Care will be answered after the initial evalua- recommendations may change according to need as the	ained to me and my questions regarding ation. I understand that these
I understand I have the right and the responsibility that I will be informed as to the nature and the purpose of	-
I have received a copy and an explanation of my righter Notice of Privacy Practices designed to protect information Bosque Valley Children's Services use and disclosure payment, treatment and health care agencies operations.	rmation regarding my child. I do consent e of protected health information for
I have been notified of my right to voice a complaint complaint with the company administrator or designee a Texas Dept. of Health, 1100 W. 49 th St., Austin, Texas The event that I need information or if a complaint is not nours, 7 days a week. This includes a complaint regarding egarding Utilization review or HMO services can be manurance, P.O. Box 149091, Austin, Texas 78714; or be	at 254-235-2430. I can also contact the 78756; or by calling 1-888-973-0022 in t resolved. The phone line is open 24 ng advance directives. Complaints ade directly to the Texas Dept. of Health
Potiant/ Porant or Authorized Panescentative	/
Patient/ Parent or Authorized Representative	Date
Patient unable to sign due to:	
BVCS Staff or designated agency representative	/

BVCS Consent form 2011 Page 2 of 2



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

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:
 - o 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 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.
 - o I must meet the yearly deductible as stated by my insurance plan.
 - o If a claim is denied for BVCS services which have been submitted on my behalf, I herby elect not to appeal the denial myself, but I do authorize BVCS to resubmit the claim for me and represent me in any negotiations.
 - o I will pay for any service charges not reimbursed by my insurance company when the BVCS bill is received.
 - o 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 / /



2124 N. 25th St., Waco, Texas 76708 Phone: 254-235-2430 Fax: 254-235-2434

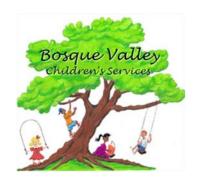
"Where our children's future begins..."

Sterling Speech & Language Services

P.O. Box 21491, Waco, Texas 76708

Parent Consent to Release Authorization from Previous Agency to Sterling Speech & Language Services, LLC dba Bosque Valley Children's Services

	offoativo	/	/
Client's Name	, effective	/	/
Medicaid# or ID#			
The last date of service provided by	Previous Agenc		, the
revious agency, was////	·		
The previous therapist's name:		ervice: []ST	[] OT
Client / Parent / Guardian		Date/	/



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

CASE HISTORY FORM

atient's nar	me:	DOB/			
Age:	M/F Address:				
arent/Guard	dian:	Address if different			
Iome Ph# _	ome Ph# Work/Cell#				
Please a	answer the following questions. If YES, p	blease explain briefly:			
Y/N V	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 A	Y / N Are there any concerns about delays in speech or language development?				
Y/N A	Y / N Are there any concerns about fine/small motor development (such as writing, etc.)?				
Y/N A	Y / N Are there any concerns about gross/large motor skills (such as walking, etc.)?				
Y/N V	Y / N Were there other developmental milestones not reached at an appropriate age?				
Y/N I	Has your child had any major accidents o	or illnesses requiring a hospital stay or surgery?			
	Has your child been diagnosed with any or vision problems, ADD.ADHD)?	chronic or ongoing conditions (ex. Diabetes,			

octor Name	Address	Address	
edications	Reasons	Length of Use	Side effects
Educational, medical):	f your child has had previou	
		ned by: Date	
Type of Eval:		ed by: Date	e of Eval.://
		IAL HISTORY	
		with others? free time?	
		that you are concerned with	
Have there be	en any major or signi	ficant changes in your child	's environment?
	SCH	IOOL HISTORY	
		ycare? Ma	
• Please explain	any concerns you ha	Addressve about your child's learning	ng:
		omplish in therapy?	
I understand that this	form and the informa	tion therein will be used by	any and all contractors of
C'anada	Б.,	/ / Relationship	. D.: