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: [ ] Speech Therapy [ ] Occupational Therapy

Date: _____ Referred by: _____

Person Providing Info: _____ Intake by: _____

Patient Information

Client name: _____ Date of Birth: _____

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

Address: _____Primary Ph #: _____

_____Alternate Ph #: _____

Email: _____

Current Therapy? Y / N If yes, explain, _____

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

_____

_____

Therapy location requested: [ ] Clinic [ ] Home [ ] Daycare/Head Start:_____

Physician Information

Physician: _____ Ph # _____

Address: _____ Fax # _____

_____

Primary Insurance Information

[ ] Medicaid is primary Medicaid #: _____ Effective Date: _____

Please select Medicaid Provider:
[ ] Amerigroup [ ] Superior [ ] Rightcare [ ] BCBS Star [ ] United Star [ ] Traditional

---------- **OR**----------

[ ] Commercial insurance is primary

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 [ ] Traditional

---------- **OR**----------

[ ] Commercial insurance is secondary

Insurance Co: _____

Insured: _____ Insur. Co. Ph# _____

Relationship to client: _____ Address: _____

Policy # _____ Group# _____

Effective Date _____ Renewal Date: _____

Insured SSN: ____ - _____ - _____ Date of Birth: _____

Employer _____ Ph# _____

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Consent for Evaluation and Release of Records; Notification of Procedures

[ ] Speech/Language 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 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.)

___ 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 herby 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, 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 1-888-252-3439.

_____ _____ / _____ / _____

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 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 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.
  - 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 _____ / _____ / _____

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Parent Consent to Release Authorization from Previous Agency to

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

Please discharge the current PAN authorization for:

_____, effective _____ / _____ / _____
Client's Name

Medicaid# or ID# _____

The last date of service provided by _____, the
Previous Agency's Name

previous agency, was _____ / _____ /_____.

The previous therapist's name: _____ Service: [ ] ST [ ] OT

_____ Date _____ / _____ / _____
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 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 your 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 _____