Let's Talk Therapy™
"...where serving you is therapeutic!"
4500 Satellite Blvd • Suite 2250 • Duluth, Georgia 30096
Office: 800-381-2195 Fax: 888-381-0822

PATIENT INFORMATION – CHILD

Name: _____

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Phone: _____

Person completing this form: _____

Relationship to Patient _____

Mother's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Father's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Care Physician's Name: _____

Primary Care Physician's Address: _____

City: _____ State: _____ Zip: _____

Other doctor(s) treating the child: _____

How did you hear about this practice?

- ☐ Doctor
- ☐ Friend/Family Member
- ☐ Self
- ☐ Other

INSURANCE INFORMATION

Please give the receptionist a copy of your insurance card

Primary Insurance: _____

Policy Holder Name: _____

Group Number: _____

Phone Number: _____

Secondary Insurance: _____

Policy Holder Name: _____

Group Number: _____

Phone Number: _____

List all children in the family from oldest to youngest

Name	Age	Sex	Grade in School	General Health

Does anyone else in the family have speech, language, or hearing problems? ☐ Yes ☐ No

If yes, please describe: _____

Has the child had any previous testing or therapy for speech, language, or hearing problems?
☐ Yes ☐ No

If yes, name of agency and date tested _____
(Please request that copies of all test results be sent to our office)

Why are you bringing your child to see us today?

_____

_____

BIRTH HISTORY

Weight of child at birth _____ Was the child full term? ☐ Yes ☐ No

Were there any unusual factors relating to the pregnancy (such as toxemia, X-ray treatments, RH negative, German measles, other illnesses, drugs or medications, previous miscarriages)?

☐ Yes ☐ No

If yes, please describe:

_____

_____

Type of birth:

☐ Normal ☐ Induced ☐ Forceps ☐ Caesarean ☐ Premature; How many weeks____?

Were there any physical deformities or malformations observed at birth (such as "blueness," jaundice, abnormal shape of head)? ☐ Yes ☐ No

If yes, please describe: _____

DEVELOPMENTAL HISTORY

In early childhood, did the child have any feeding problems (such as poor control of sucking, food allergies, digestive upsets)? ☐ Yes ☐ No

If yes, please describe: _____

Give ages of development for the following behaviors:

Sitting unsupported	_____	Walking	_____
Eating solid foods	_____	Self-feeding	_____
Crawling	_____	Self-dressing	_____
Standing alone	_____	Bladder/bowel control	_____

Do you feel that the child was late or had difficulty in the development of these behaviors?

☐ Yes ☐ No

MEDICAL HISTORY

Date and type of last medical examination _____

List ages for any of the following childhood diseases:

Whooping cough	_____	Pneumonia	_____
Mumps	_____	Chicken Pox	_____
Measles	_____	Tonsillitis	_____
Rheumatic fever	_____	Other:	_____

Were there any complications with any of the above, such as high/persistent fevers, convulsions, or persistent muscle weakness? ☐ Yes ☐ No

If yes, please explain: _____

Has the child had allergies, hay fever, etc.? ☐ Yes ☐ No

If yes, please describe: _____

Has the child had any operations? ☐ Yes ☐ No

If yes, please describe: _____

Has the child had tonsils and adenoids removed? ☐ Yes ☐ No

If yes, when? _____

Has the child had any ear trouble (such as earaches, infection, running ears, evidence of hearing loss)? ☐ Yes ☐ No

If yes, please describe: _____

Has hearing been tested? ☐ Yes ☐ No If yes, when? _____

Results: _____

Has the child ever had ear (PE) tubes inserted? ☐ Yes ☐ No

If yes, when? _____

If yes, does the child still have ear (PE) tubes? ☐ Yes ☐ No

Does the child have any dental problems? ☐ Yes ☐ No

If yes, please describe: _____

Has the child seen a specialist for any reason? ☐ Yes ☐ No If yes, please explain:

_____

_____

EDUCATION HISTORY

Current School _____

Address _____

City _____ State _____ Zip _____

Grade Teacher

Does the child attend any special classes (such as speech therapy, language development, reading, resource room, special education classroom)? ☐ Yes ☐ No

If yes, please describe:

_____

_____

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TREATMENT AUTHORIZATION

I agree to allow Let's Talk Therapy, LLC to provide speech and language services for me or my child. In addition:

- ☐ I have seen and agree with the treatment goals and therapy plan.
- ☐ I agree to attend scheduled therapy sessions (see attendance policy).
- ☐ I agree to participate in my child's/loved one's treatment, as appropriate.
- ☐ I understand that my child/loved one may be given work to do at home. I agree to help my child/loved one do this work to help with treatment goals.

Print Patient Name	Date
Patient or Parent/Guardian Signature	Relationship to Patient

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Acknowledgment That You Have Received Our HIPAA Privacy Notice

Let's Talk Therapy is required by law to keep your health information safe. This information may include:

- notes from your doctor, teacher, or other health care provider
- your medical history
- your test results
- treatment notes
- insurance information

We are also required by law to give you a copy of our privacy notice. This notice tells you how your health information may be used and shared. It also tells you how you can look at and comment on your information.

By signing this page, you are saying that you have been given a copy of our privacy notice.

Print Patient's Name	Date
Patient or Parent/Guardian Signature	Relationship to Patient

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ATTENDANCE POLICY

Thank you for choosing Let's Talk Therapy, LLC. We want to provide the best possible services to all of our patients. We will do our best to schedule appointments that meet your needs. Regular attendance is important to you/your child's success. We ask that you follow the attendance policies outlined below:

1. **Cancellations:** Please call us at least 24 hours in advance to cancel your appointment. If you fail to give us proper notice after 2 cancellations, we reserve the right to (a) place your services on hold, (b) discharge you until scheduling conflicts can be worked out, or (c) charge a $25.00 fee on your next visit and thereafter for each cancellation. Insurance will not cover this fee.
2. **Missed Appointments:** We will attempt to reschedule missed appointments with your current therapist if they have the availability. If not, we will reschedule you with another therapist.
3. **Late for Appointments:** If you are more than 15 minutes late for your appointment, we reserve the right to reduce the therapy session by the number of minutes late or cancel the therapy session and consider it a missed appointment (See policy for Missed Appointments above).
4. **No Call/No Show:** If you do not call to cancel your therapy session, (a) a $25 fee will be due on your next visit for your first offense, (b) a $50 fee will be due on your next visit for your second offense (c) you will be discharged from services on your third offense.
5. **Clinician Cancellations:** If your therapist is not able to attend your appointment, you will be contacted as soon as possible. Please be sure that our office knows the best way to reach you. Every effort will be made to reschedule your appointment in a timely manner.
6. **Inactive Insurance:** If your insurance becomes inactive, you run the risk of losing your scheduled appointment times and may be possibly assigned to a different therapist when insurance becomes active.

Regular attendance is very important! Your insurance requires your child to improve while receiving services. If your child misses frequently, your insurance will not approve additional visits due to lack of progress associated with missed visits, which will result in your child being discharged from treatment. No call no shows, last minute cancellations, etc. are subject to the clinic's discretion of patient dismissal.

To cancel your appointment, please call our office at least 24 hours in advance at 800-381-2195.

_____ _____

Patient or Parent/Guardian Signature Date

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ASISTENCIA POLÍTICA

Gracias por elegir la terapia Hablemos, LLC. Queremos ofrecer el mejor servicio posible a todos nuestros pacientes. Haremos nuestro mejor esfuerzo para programar citas que se ajusten a sus necesidades. La asistencia regular es importante para usted / éxito de su hijo. Le pedimos que siga las políticas de asistencia se detallan a continuación:

1. **Cancelaciones:** Por favor, llámenos al menos 24 horas de anticipación para cancelar su cita. Si no nos notifica después de 2 cancelaciones nos reservamos el derecho de (a) Poner sus servicios en suspenso (b) Quitarlos del calendario hasta que se puedan resolver los conflictos de programación o (c) cobrar una tarifa de $25.00 por cada cancelación después. El seguro no cubrirá esta quota.

2. **Citas Perdidas:** Intentaremos reprogramar las citas perdidas con su terapeuta si tiene la disponibilidad. Si no le reprogramaremos con otro terapeuta.

3. **Tarde a las Citas:** Si son más de 15 minutos tarde a su cita, nos reservamos el derecho de reducir el tratamiento por el número de minutos de retraso y / o cancelar la cita y consideramos que es una cita perdida (ver política de faltar a las citas anteriores).

4. **Ninguna llamada / No demostración:** Si no llama para cancelar su sesión de terapia, (a) una quota de $25 se le cobrara en su próxima visita por su primera ofensa. (b) Una quota de $50 se le cobrara en su próxima visita por su segunda ofensa (c) Será dado de alta de los servicios en su tercera ofensa.

5. **Cancelaciones Médico:** Si su terapeuta no es capaz de asistir a su cita, usted será contactado tan pronto como sea posible. Por favor, asegúrese de que nuestra oficina tenga la mejor manera de comunicarse con usted. Cada esfuerzo se hará para cambiar su cita de manera oportuna.

6. **Seguro Inactivo:** Si su seguro se vuelve inactivo, corre el riesgo de perder sus horarios de citas programadas y posiblemente puede asignarse a un terapeuta diferente cuando el seguro vuelva a estar activo.

¡La asistencia regular es muy importante! Su seguro requiere que su hijo mejore mientras recibe servicios. Si su hijo pierde frecuentemente su seguro no aprobará visitas adicionales debido a la falta de progreso asociado con las visitas perdidas, lo que resultará en que su hijo sea dado de alta del tratamiento. Ninguna llamada no muestra, cancelaciones de última hora, etc están sujetos a la discreción de la clínica de despedir al paciente.

Para cancelar su cita, por favor póngase en contacto con el terapeuta el tratamiento, o con nuestra oficina al 800-381-2195.

_____ _____

Paciente o Padre / Firma del Padre Date

Admin Initials: ____

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HIPAA - Your Privacy Rights

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: _____

Let's Talk Therapy is required by law to keep your health information safe. This information may include:

- notes from your doctor, teacher, or other health care provider
- your medical history
- your test results
- treatment notes
- insurance information

A government rule, called the Health Insurance Portability and Accountability Act, or HIPAA, requires that you get a copy of this privacy notice. We will ask you to sign a paper saying that you have been given this notice.

Read and refer to this notice at any time to see how your health information can be used and who can see it.

How Your Health Information May Be Used or Shared

We may use or share your health information without your permission for the following reasons:

- **Treatment.** We may share information with doctors and other health care providers who care for you. For example, if your doctor orders speech therapy, we will share the results of our treatment with that doctor.

- **Payment.** We may use and share information about the treatment you receive with your insurance company or other payer to receive payment for services. This may include sharing important medical information. We may share information to:
    - get the insurance company's permission to start treatment
    - get permission for more treatment
    - get paid for the treatment you receive

- **Health Care Operations.** We may use and share your health information to run the clinic and be sure that all patients receive good care. For example, we may use your health information to:
    - see how well our services are working
    - see how well our staff is doing
    - see how we compare to other clinics
    - make our services better
    - help others study health care services

Your Health Information May Also Be Used or Shared <u>Without</u> Your Permission for:

- **Abuse and Neglect.** We may share your health information with government agencies when there is evidence of abuse, neglect, or domestic violence.
- **Appointment Reminders.** We will use your information to remind you of upcoming appointments. Reminders may be sent in the mail, by e-mail, or by phone call or voicemail message. If you do not wish to get reminders, please tell your speech-language pathologist.
- **As Required by Law.** We will share your information when we are told to do so by federal, state, or local law. We will also share information if we are asked by the police or courts.
- **Government Functions.** Your information may be shared for national security or military purposes. If you are a veteran, your information may be shared with the Office of Veteran's Affairs.
- **Information About a Person Who Has Died.** We may share information with the coroner, medical examiner, or a funeral director, as needed.
- **Marketing.** We may use your information to let you know of other services that might be of interest to you.
- **Public Health Risks.** We may report information to public health agencies as required by law. This may be done to help prevent disease, injury, or disability. It may also be done to report medical device safety issues to the Food and Drug Administration and to report diseases and infections.
- **Regulatory Oversight.** We may use or share your information with agencies overseeing health care. This may include sharing information for audits, licensure, and inspections.

- **Research**. We may share your health information with researchers to be included in their research project. Information will be shared only for projects that have been through a special approval process. These projects have rules to protect your privacy, too.
- **Threats to Health and Safety.** Your health information may be shared if we believe that it will prevent a threat to your health and safety or the health and safety of others.
- **Worker's Compensation.** We will share your information with Worker's Compensation if your case is being considered as a work-related injury or illness.

When Your Permission Is Needed to Use or Share Your Health Information

You must give us permission to use or share your health information for any situation that is not listed in this notice. You will be asked to sign a form, called an authorization, to allow us to use or share your information. You are allowed to take back this authorization, called revoking authorization, at any time. We will not be able to get back the information that we shared with your permission.

Your Privacy Rights

You have the right to:

- **Ask us not to share your information.** You can ask us not to use or share your information for treatment, payment, or health care operations. You can also ask us not to share information with people involved in your care, like family members or friends. You must ask for limits in writing. We must share information when required by law. We do not have to agree to what you ask.
- **Ask us to contact you privately.** You can ask us to contact you only in a certain way or at a certain place. For example, you may want us to call you but not to e-mail you. Or you may want us to call you at work and not at home. You must ask us in writing. We will do all we can to do what you ask.
- **Look at and copy your health information**. You have the right to see your health information and to get a copy of that information. You have a right to see treatment, medical, and billing information. You may not be able to see or copy information put together for a court case, certain lab results, and copyrighted materials, such as test protocols.
- **Ask for changes to your health information**. You can ask us to change information that you think is wrong. You can also ask that we add information that is missing. You must ask us in writing and give us a reason for the change. We do not have to make the change.
- **Get a report of how and when your information was used or shared.** You can ask us to tell you when your information was shared and who we shared it with. There are some rules about this:
    - You need to ask us in writing.
    - You must tell us the dates you are asking about and if you want a paper or electronic copy.
    - You may get information going back 6 years, but it cannot be for earlier than April 14, 2003. This is the date when the government privacy rules took effect.

- **Get a paper copy of this privacy notice.** You can get a paper copy of this notice at any time. You can get a copy even if you have already signed the form saying you have seen this notice.
- **File complaints.** You can file a complaint with us or with the government if you think that:
  - your information was used or shared in a way that is not allowed
  - you were not allowed to look at or copy your information
  - any of your rights were denied

Who Is Covered by This Notice

The people who must follow the rules in this notice are:

- all speech-language pathologists working at [insert practice name here]
- anyone who is allowed to add health information to your file, including students and other staff
- any volunteers who may help you while you are in this clinic

Changes to the Information in This Notice

We may change this notice at any time. Changes may apply to information we already have in your file and to any new information. Copies of the new notice will be available from our staff. The notice will have a date on the front page to tell you when it went into effect.

Complaints

You may file a complaint if you think we did something wrong with your information. You can complain to your regional office of the United States Office of Civil Rights. To find out more about filing complaints, go to www.hhs.gov/ocr/privacy/hipaa/complaints/index.html. All complaints must be in writing. You will not get in trouble for filing a complaint.

Contacts

If you have any questions about this notice or your privacy rights, please ask your speech-language pathologist.