Austin Area Speech and Language Services
3101 Bee Caves Road, Suite 210
Austin, TX 78746
(512) 327-2083
Fax (512) 327-0808

CASE HISTORY

General Information **Today's Date:**

Name of Client: _____ Date of Birth: _____ Gender: _____

Address: _____ Zip: _____

Parent #1 Name: _____ Phone*: _____ ☐ home ☐ mobile ☐ work

Parent #2 Name: _____ Phone*: _____ ☐ home ☐ mobile ☐ work

**Please note that our office requires 2 phone numbers for our records*

Email Address: _____ Who referred you to us? _____

Pediatrician Name, Address, & Phone #: _____

Languages spoken at home: _____

Please list family members/others living in the home (i.e., sister, brother, grandfather, uncle)

_____

Birth, Early Development, & Medical History:

Birth Weight: _____ ☐ Premature ☐ Full term

Were there any complications during the pregnancy or delivery? (Please explain) _____

_____

Was your child a quiet or noisy baby? _____

Were there any early feeding problems? (Please explain) _____

Did your child/does your child use a pacifier or suck their thumb? (Please explain) _____

What was the end date of pacifier use or thumb sucking? _____

Is your child a chronic mouth breather? ☐ Y ☐ N Does your child snore? ☐ Y ☐ N

Has your child's hearing been evaluated other than at birth? ☐ Y ☐ N Date of hearing test: _____

From the hearing test, was any hearing loss detected? ☐ Y ☐ N

Does/Did your child have frequent ear infections? ☐ Y ☐ N If so, approximate number & ages: _____

Does your child have pressure equalizing tubes? ☐ Y ☐ N Date placed? _____

Does your child have any allergies? If so, please list: _____

Does your child suffer from seasonal allergies? If so, please list: _____

At what age did your child reach the following developmental milestones:

Began crawling _____Began walking _____ Drinking from a cup _____Eating solid foods _____

Birth, Early Development, & Medical History: *(continued)*

Has your child been seen by any of the following professionals: (**Please provide name, date & results/additional information**):

- ☐ Ear, Nose & Throat Doctor _____
- ☐ Audiologist _____
- ☐ Neurologist _____
- ☐ Speech Pathologist _____
- ☐ Physical Therapist _____
- ☐ Occupational Therapist _____
- ☐ Educational Psychologist _____
- ☐ Other Specialist (please specify) _____

Has your child had any serious illnesses, accidents, or injuries? (Please describe)

_____

_____

Please list any medications your child is currently taking: _____

Speech & Language Development:

Please describe in your own words your child's speech and language challenges:

_____

_____

When did you notice difficulty in your child's speech and/or language skills?

_____

Has change occurred in his/her skills in the past few months?

_____

_____

At what age did your child reach the following developmental milestones:

Say first words _____Combine two words together _____Use short sentences _____

Is there any history of speech, language, or learning issues in the family? (Please explain)

_____

Educational History:

Name of school your child is currently attending _____

Grade _____ Teacher _____

Are there any concerns about your child's academic performance? (Please describe)

_____

_____

Educational History, *continued*

Has your child been evaluated by any professionals at his/her school ☐ Y ☐ N

If yes, please explain _____

Please describe any social or behavioral concerns encountered at school or home:

_____

_____

Please describe your child's strengths & weaknesses:

_____

_____

Is there anything additional you would like us to know about your child?

_____

_____

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Patient Information

Patient's Name: _____ Date of Birth: _____

Parent #1 Name: _____ Phone*: _____ ☐ home ☐ mobile ☐ work

Parent #2 Name: _____ Phone*: _____ ☐ home ☐ mobile ☐ work
**Please note that our office requires 2 phone numbers for our records*

Parent #1 Occupation: _____ Parent #2 Occupation: _____

Email Address: _____

Home Address: _____ Zip: _____

Insured's Name _____ Insured's DOB: _____

Insured's ID or Policy# _____Group #_____

Insured's Employer: _____

Insurance Company: _____

Insurance Company Address: _____

Insurance Co. Phone number(s): _____

Do you know what your deductible is? _____ Have you met this deductible? _____

What is your copay amount? _____

Physician's Name: _____ Phone Number: _____

Referral # (if applicable): _____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE
I authorize the release of any medical or other information necessary to process this claim with my insurance company.

Signed: _____ Date: _____

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Insurance Coverage Advanced Notice Service Waiver

Provider's Notice

Some health insurance plans will only pay for services that they determine to be "reasonable and necessary." If an insurance plan determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary," the insurance plan may deny payment for that service. Please know that we will make all efforts to collect the amounts due from the insurance provider, including following any appeals process that the provider has in place for collection of these claims.

Policyholder Patient Agreement

I, _____, have been informed on this date _____
by my speech therapy provider (and/or staff) that, as with any claims submitted by a healthcare provider, that my health plan may deny payment for the services I am pursuing here at Austin Area Speech & Language Services. I understand that if the health plan denies payment, I agree to be personally and fully responsible for payment of the service(s) rendered. In the event that my insurance carrier recoups all or part of any payments made to Austin Area Speech & Language Services on my behalf, that I am responsible to pay this recouped sum as well.

_____ _____
Policyholder/Representative/Patient Signature Staff Signature

Required Payment Information

Due to difficulties recouping unpaid invoices AASLS now requires that patients have a valid credit card on file to pay any invoices that are unpaid 10 days after the final visit or after an invoice has been given. Note that if payments are paid with PayPal or with a credit card, that a 3% fee will be added to invoices. To avoid the fee, patients can pay with Zelle using email address sdejernett@austinareaspeech.com, with a personal check or other approved payment method (see your therapist for a complete list.)

I authorize AASLS to charge my credit card for the purpose of meeting my financial obligation to AASLS. My credit card information is as follows:

Name on Credit Card: _____ Card Type: _____

Card #: _____ Expiration Date: _____

Zip Code: _____ CVV Code: _____
Email address where you would like us to send your receipt: _____

Signature: _____ *Date:* _____

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Communication Consent

Austin Area Speech & Language Services respects your right to confidential communication about your protected health information as well as your right to direct how these communications occur. Email and texting can be an insecure method of communication and therefore we will only communicate with you by email or text following receipt of your written consent. Your consent will include the phone number and email address that you provide on this form, and unless additional written consent is provided for additional numbers or email addresses to be added or changed, only the phone numbers and email addresses included below will be used for the associated modes of communication.

When you consent to communicating with us by email or text you are consenting to email and texting communications that may not be encrypted. In addition, voicemail or answering machine messages may be intercepted by others. Therefore, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information when you consent to communicating with us through phone, voicemail, email, or text.

Austin Area Speech & Language Services will not be responsible for any privacy or security breaches that may occur through voicemail, email, or text communications that you have consented to. In addition, our speech pathologists cannot guarantee confidentiality of email and text information sent and received but will use reasonable means to maintain this security. We will not forward client's/parent's/legal guardian's identifiable emails and/or texts without the client's/parent's/legal guardian's written consent, except as authorized by law.

You may choose to only provide specific means of communication, which you can indicate below. Please check all that apply:

☐ I consent to receiving communication about the scheduling of appointments or other communications that do not reveal my protected health information ONLY by the following means ***(check all that you consent to):***

- ☐ Email
- ☐ Text
- ☐ Voicemail

☐ I consent to all communication, including but not limited to communication about my diagnosis, treatment, and advice from my speech pathologist by the following means ***(check all that you consent to)***:

- ☐ Email
- ☐ Text
- ☐ Voicemail

E-mail address you are consenting to communicate through: _____

Phone number you are consenting to communicate through: _____

Patient Signature/Guardian if under age 18: _____Date Signed _____

Provider Signature: _____ *Date Received:* _____

Austin Area Speech and Language Services

NOTICE OF PRIVACY PRACTICES

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.

This notice describes how we may use and disclose your Protected Health Information (PHI) for purposes of treatment, payment, health care operations, and for other purposes that are permitted or required by law.

OUR RESPONSIBILITIES

Austin Area Speech and Language Services is required by law to:

- Maintain the privacy of your health information
- Provide you with a copy of this Notice describing our duties and privacy practices as to the information we collect and maintain about you
- Abide by the terms of our current Notice
- Accommodate reasonable requests to communicate with you about your health information.

We reserve the right to change, amend or eliminate provisions in our privacy practices and to make the new provisions effective for all health information we keep. Should our privacy practices change, we will amend our notice. You are entitled to receive a copy of the amended notice by calling and requesting a copy of the amended notice or by visiting our office and picking up a copy. We will not use or disclose your health information without obtaining a signed authorization from you except as described in this Notice or as otherwise permitted or required by law; for example, in emergency treatment situations.

HOW WE MAY USE AND DISCLOSE YOUR PERSONAL HEALTH INFORMATION

- **For Treatment:** We may use your health information to provide you with healthcare treatment and to coordinate services with other healthcare providers such as your referring physician. We may disclose your health information to family members or friends, guardians or personal representatives who are involved with your medical care. We may also use your health information to contact you for appointment reminders. We may also disclose your healthcare information to people outside this facility who may be involved in your healthcare after your leave our facility.
- **For Payment:** We will use and disclose your health information to receive payment for our services and determine insurance coverage. We will also use your health information for billing, collection, claims, and medical data processing. We will use and disclose your health information to business associates that we have contracted to perform agreed upon services i.e., billing service and accountant.
- **For Healthcare Operations:** We may disclose your healthcare information for routine operations in this clinic, such as business planning and development, quality review of services provided, licensing or credentialing activities, certification, internal auditing, accreditation, and education for staff.
- **For Research:** We may use your health information for research purposes subject to special approval by you.
- **For Video/Audio Recording:** For evaluations and therapy, the therapist might need to record the session. This is required so that the therapist can review information once the session is completed. This information will be used by Austin Area Speech and Language Services staff only.
- **For Emailing:** Some parents wish to communicate via email. If you give us your email address, you are consenting to communicating via email.
- **Serious Threat to Health or Safety:** We may disclose your health information when necessary to prevent a serious threat to your health and safety or the health and safety of another person or the public. We may use or disclose health information about you without your prior authorization for several reasons. Subject to certain requirements, we may give our health information about you without your prior authorization for public health purposes, abuse or neglect reporting, health oversight audits or inspections, medical examiners, funeral arrangements, organ donation, workers' compensation purposes, emergencies, national security and other specialized government functions. We also disclose health information when required by law, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders or other legal process, such as court order or subpoena.

Your Rights Regarding Your Health Information

- You may request a copy or summary of your health information, or you may inspect it. If you request a copy, we may charge a fee for the cost of copying and mailing associated with the request. Texas law allows fifteen days for us to complete your request. We will inform you when records are ready. If we deny your request, we will do so in writing.
- You may request an amendment to your health information if you feel there is an error.
- You have the right of refusal to sign an authorization and it is not held against you.
- You may change your mind and revoke your authorization, except where actions have already been taken by us relating to that authorization. Requests must be made in writing and submitted to the privacy officer at Austin Area Speech and Language Services.
- You have the right to an accounting of all entities with whom we have shared or disclosed your health information unrelated to treatment, payment or healthcare operations.
- You may request a restriction on certain uses of your health information (we will consider reasonable, appropriate requests but are not obligated to agree to them).
- You have the right to obtain a paper copy of this Notice of Privacy Practices.
- You may file a complaint if you believe that your privacy rights have been violated. Any requests or other communications about the rights listed above should be directed to: Austin Area Speech and Language Service's privacy officer at 512-327-2083 or 3101 Bee Caves Road, Suite 210, Austin, TX 78746 or to the Secretary of the Department of Health and Human Services, 200 Independence Avenue SW, Washington DC 20201.

We reserve the right to change this notice. The revised or changed notice will be effective for the information we have about you as well as any information we receive in the future.

Updated October 2021

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Acknowledgement of Receipt of Notice of Privacy Practices

Please sign below to indicate you have received a copy of Austin Area Speech and Language Services' Notice of Privacy Practices on the date indicated. If you have any questions regarding our Notice of Privacy Practices, please contact Austin Area Speech and Language Services' Privacy Officer at 512-327-2083.

Patient Name: _____ Patient Date of Birth: _____

Patient Representative: _____ Relationship to Patient: _____

Signature: _____ Date: _____

Release of Information

I authorize an exchange of information between Austin Area Speech & Language Services and the agencies and/or personnel listed below. I give my permission to relay information regarding my child's therapeutic records (evaluations, treatment plans, therapy notes, etc.) via email and/or phone conversations with the following individuals:

_____
_____
_____

_____ _____ _____
Parent Signature *Printed Name* *Date*

Consent to Evaluate

I give Austin Area Speech & Language Services my permission to evaluate my child,

_____
(Print name)

I understand that the results of the evaluation are confidential and will not be released to anyone without my written authorization.

_____ _____ _____
Parent Signature *Printed Name* *Date*

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Cancellation Policy

We ask that you notify us of any cancellations (for evaluation or treatment sessions) at least 2-4 hours in advance. Please understand that we reserve that time just for you and/or your child and that we spend valuable time planning activities.

Failure to notify us will result in a **$30 charge for the first occurrence** (payable at your next visit). Thereafter, **a $50 charge will apply for subsequent occurrences** (payable at your next visit).

If you cancel without reasonable cause greater than 50% of your scheduled visits or "no show" (this means you fail to show up or call at all or until after the session is complete) twice or more within a six-week period, we reserve the right to discharge and fill your time slot with another client.

You or your child's progress depends greatly on his/her consistent attendance and the continuity of the treatment plan. Your cooperation and understanding are greatly appreciated.

_____
Client/Parent Signature

_____
Printed Name

_____
Date