

PATIENT INFORMATION

Patient Name _____ DOB: __/__/____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Responsible Party: _____ DOB: __/__/____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Cell: _____

Social Security #: _____ - _____ - _____ Relation to Patient: _____

Employer: _____ Phone #: _____

Responsible Party's Spouse: _____ DOB: __/__/____

Social Security #: _____ - _____ - _____ Cell: _____

Employer: _____ Phone #: _____

Insurance Company: _____ Policy #: _____

Address of Ins. Co.: _____ City: _____

State: _____ Zip: _____ Phone #: _____

Emergency Contact Information

Name: _____ Relation: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone #: _____

CASE HISTORY

Please fill out this form as completely as possible, and return it to the clinic by the day of your initial evaluation.

NOTE: ALL INFORMATION GIVEN IS KEPT CONFIDENTIAL.

Person completing this form: _____

Relationship to patient: _____

I IDENTIFICATION

Child's Name: _____ DOB: _____ Age: _____

Address: _____ Phone (H) _____

City, St., Zip: _____

Parents (Check one) Married: _____ Divorced: _____ Separated: _____

If parents don't live together, describe custody arrangement of child: _____

Referred by: _____ Phone: _____

List all doctors seen routinely: _____

II BACKGROUND INFORMATION

Describe your concerns (re: speech/language): _____

When was the problem first noticed? _____

By Whom? _____

What changes in your child's language, speech or hearing have you noticed since that time? _____

What do you think caused the problem? _____

List people you have consulted about the problem:

Date	Name/Address	What were you told about the problem?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Child's Name: _____

Has your child ever had speech or language therapy? _____

When? _____ Where? _____

Speech, Language and Hearing History

1. What language is spoken at home? _____

2. When did child say his/her first word? _____

Use 2-word phrases? _____ Use Sentences? _____

3. Did speech/language learning ever seem to stop for a period of time? _____

Describe: _____

4. How well can child be understood by his/her immediate family? _____

How well can child be understood by others? _____

5. Circle the one your child uses most often:

Sentences Phrases One or two words Sounds Gestures

6. Do you question your child's ability to understand directions and conversations? _____

Why? _____

7. Does your child hesitate, "get stuck", repeat or stutter on sounds or words? _____

If so, describe: _____

How often? -. _____

8. Can your child read? _____ -When did your child start reading? _____

9. Does your child's voice sound hoarse? _____ Low-pitched? - _____ Nasal? _____

10. Do you think your child hears adequately? _____ Do you think that his/her hearing changes

from day to day? _____

11. Has your child's hearing been checked recently? _____ If so, what were the results?

Developmental History Note the ages when the following occurred:

hold head erect _____
follow object with eyes _____
roll over from back to stomach _____
reach for objects _____
dress self _____
toilet trained _____

crawl _____
feed self with spoon _____
sit unsupported _____
stand alone _____
walk alone _____

1. Is child well coordinated? _____

2. Is child clumsy? _____

3. Does child lose balance or fall easily? _____

Medical History

Child is our: Biological _____ Adopted _____ Foster Child _____

Number of pregnancies mother has had: _____ Which was this child? _____

Child's Name: _____

1. Did mother have any of the following? What month? Was hospitalization necessary?

Bleeding	_____	Virus infection	_____	Accidents	_____
Swelling	_____	German measles/Rubella	_____	Surgeries	_____
High blood pressure	_____	Diabetes	_____	Smoking	_____
Low blood pressure	_____	Heart Condition	_____	Toxemia	_____
Convulsions	_____	Asthma	_____	X-rays	_____
Kidney disease	_____	Rh negative blood	_____	Anesthetics	_____
Excessive gain/loss	_____	Thyroid condition	_____	Drinking alcohol	_____

Medications
(What?) _____

2. What was the length of pregnancy? _____

3. What was the length of hard labor? _____

4. Type of delivery(circle): vertex(head presentation) breech cesarean dry other

5. Were there any unusual problems at birth?(If so, describe) _____

6. Birth weight _____

7. Apgar score at 1 minute: _____ at 5 minutes: _____

8. Were there any health problems during the first two weeks of infant life?

Jaundice	_____	Transfusions	_____	Hemorrhage	_____
Blueness	_____	Oxygen	_____	Tube fed	_____
Difficulty breathing	_____	Feeding difficulty	_____	Infection	_____
Convulsions	_____	Incubator or isolette	_____		

Was first cry: strong _____ weak _____ high _____

Were intravenous or intramuscular fluids required? _____

9. How long did child remain in hospital? _____

10. Did child require intensive care or observation? _____

11. Is there any other information about the mother or baby which can help us to evaluate your child? _____

12. At what ages did any of the following illnesses or surgeries occur? Indicate severity and temperature.

Whooping Cough	_____	Ear Infections	_____
Mumps	_____	Draining Ears	_____
Scarlet fever	_____	P.E.Tubes insertion	_____
Measles	_____	Tonsillectomy	_____
Chicken Pox	_____	Adenoidectomy	_____
Pneumonia	_____	Allergies	_____
Diphtheria	_____	Epilepsy	_____
Croup	_____	Encephalitis	_____
Influenza	_____	Typhoid	_____
Headaches	_____	Tonsillitis	_____
Sinus	_____	Chronic Colds	_____
Meningitis	_____	Head Injuries	_____
Rickets	_____	Mastoidectomy	_____
Rheumatic feve.	_____	Asthma	_____
Polio	_____	Dental problems	_____

Other: _____

AREAS OF CONCERN

- Difficulty swallowing
- Mouthing objects inappropriately
- Excessive drooling
- Biting, pinching, etc.
- Uses only 1-2 words
- Refusal to obey
- Echolalia
- Stuttering
- Poor sentence structure
- Difficulty answering questions
- Poor social interaction
- Misarticulating of words
- Seizure activity
- Impulsiveness
- Difficulty with change
- Dislikes being touched
- Places self in dangerous situations
- Clumsy, trips often
- Weakness in arms, legs, trunk
- Poor balance
- Unable to catch tossed ball
- Delay in sitting up
- Toe-walks
- Spins inappropriately
- Poor handwriting
- Poor hygiene
- Uses one hand more than other hand
- Strong gag reflex
- Difficulty climbing stairs
- Poor trunk control
- Difficulty chewing food
- Picky eater
- Inappropriate toy play
- Does not understand simple directions
- Difficulty sleeping
- Runs from parents, teachers, etc.
- Distractibility
- Poor/inappropriate eye contact
- Pronoun misuse
- Poor attention to task
- Numerous ear infections
- No verbal language
- Bedwetting
- Thumb sucking
- Fixates on television/videos
- Dislikes malls, shopping centers, etc.
- Prefers certain foods
- Poor eye-hand coordination
- Unable to ride bicycle
- Fear of swings, playground equipment
- Increased muscle tone in arms, legs
- Delay in pulling up, crawling
- Lines up objects
- Weak hand muscles
- Unable to dress/undress self
- Unable to skip or hop on one foot
- Cannot feed self independently
- Intolerant to textures on hands/feet
- Hums to self
- Uncoordinated running pattern

Please list below any other concerns you have regarding your child:

Consent for Secure/Release of Information

Name: _____ Date of Birth _____

Address: _____

I/WE hereby authorize and request Little Works in Progress to secure and /or release medical, social, educational, and other clinical information regarding the patient named above. I/WE understand that this authorization maybe revoked in writing at any time. Otherwise this consent automatically expires two years from the date of signature. **This authorization applies only to the following individuals/institutions: If not completed, no information will be released from our office.**

Primary Care Physician: _____

Address: _____

Insurance Carrier: _____

Address: _____

Name _____

Address: _____

I/We give permission for the therapist and or staff at Little Works in Progress to disclose/request information regarding scheduling of school based appointments, therapy, school performance, and/or any information deemed relevant to academic and therapy success. Information will not be disclosed to anyone not specifically listed below.

School Name: _____

Name: _____ Name: _____

Name: _____ Name: _____

I/We give permission for Little Works in Progress to communicate via email, information, i.e. evaluations, therapy updates, and/or other clinical information regarding the patient listed above. Information will not be disclosed to anyone not specifically listed below.

Email Address: kimberly@littleworksinprogress.com Email Address: _____

Email Address: ashley@littleworksinprogress.com Email Address: _____

I hereby further direct that a copy of this authorization shall be deemed to be as valid as the original for all purposes authorized herein.

Signature: _____ Date: _____

Relationship (if person named above is a minor) _____

Witness signature: _____

Patient Rights and Responsibilities

Summary of Patients Rights:

- The right to considerate, confidential, private, and respectful care.
- The right to understandable information about your diagnosis and possible treatments.
- The right to know the name, role, and credentials of the people treating you.
- The right to privacy of treatment records unless you have given permission to release information.
- The right to review your treatment records and to have the information explained.
- The right to know if Little Works In Progress has relationships with outside parties that may influence your care.
- The right to give consent or decline any part of treatment. If you choose not to take part, you will receive the most effective care Little Works In Progress otherwise provides.
- The right to know about our office policy that affects you and your treatment.
- The right to an itemized bill of charges and payments.
- The right to know about and have access to office resources, such as directors, administrators, and coordinators, that can help you resolve problems and questions about your office visit and care.
- The right to a quick response from our Administrative team regarding any comments, questions, or complaints.

Summary of Patient's Responsibilities:

- The responsibility to be prompt for all scheduled appointments.
- The responsibility of notifying the office 24 hours in advance of cancellation.
- The responsibility of providing any information regarding previous evaluations, or health issues such as allergies or special diets.
- The responsibility of providing Little Works In Progress with correct and/or updated information regarding address, telephone, change of custody status, insurance coverage (Insurance card).
- The responsibility of asking questions when you do not understand instructions or information.
- The responsibility to notify your therapist if you are unable or unwilling to follow therapy recommendations.
- The responsibility of being considerate of the needs of other patients and staff.
- The responsibility to assure appropriate behavior of all non-patient visitors brought to our office.
- The responsibility to pay co payments or fees for services received at the time of treatment.
- The responsibility to meet with the business office if payment arrangements need to be made due to unforeseen circumstances.
- The responsibility to know and confirm benefits prior to receiving treatment.
- The responsibility to verify that Little Works In Progress is/is not providing services within the network of your insurance coverage.



PRIVACY NOTICE ACKNOWLEDGEMENT

I have received a copy of *Notice of Privacy Practices*; as well as, *Patient Rights and Responsibilities*.

Signature of Responsible Party

Date

CANCELLATION AND NO SHOW POLICY

Our clinic is open Monday through Thursday. All sessions are by appointment only. It is the patient's responsibility to attend all scheduled appointments.

Should you need to cancel an appointment, **all cancellations MUST be made by 9:00 a.m. the day of your child's therapy session or the responsible party will be billed as a NO-SHOW.** When possible, a 24 hour cancellation notice is appreciated.

If prior notification is not received in a timely manner as stated above, the following NO-SHOW rate will be billed to the responsible party. These fees **CANNOT** be billed to your insurance.

Speech Therapy session: \$55.00

Occupational Therapy session: \$65.00

Physical Therapy session: \$75.00

If a break in therapy lasting longer than 2 weeks occurs, your child will be removed from the schedule, unless prior arrangements have been made. It is the parents responsibility to reschedule their child's therapy sessions.

If 75% or more scheduled therapy sessions are not kept within each calendar month, your child will be removed from the schedule.

If 2 or more No Shows occur within a calendar month, your child will be removed from the schedule.

Reminder: We do encourage make-up sessions!

By my signature below, I acknowledge that I have read the terms outlined in the Cancellation and No Show Policy, and agree to honor the terms of this policy.

Child's Name: _____

Responsible Party: _____

Today's Date: _____

INSURANCE/CREDIT POLICY

Charges for services at Little Works In Progress are due and payable at the time services are rendered. In the event other arrangements are made, a statement will be mailed to you with payment due upon receipt. **THE RESPONSIBLE PARTY IS RESPONSIBLE FOR PAYMENT REGARDLESS OF THE STATUS OF THE INSURANCE CLAIMS.**

When insurance claims go over 30 days without payment, the responsible party must pay claims out of pocket at the time services are provided. If the insurance company reimburses for claims already paid by the responsible party a refund check will be issued. Once all claims are paid to 30 days or less, the responsible party will no longer be required to pay out of pocket, other than customary co-pays and deductibles, at the time of therapy.

Except when hardship warrants otherwise, accounts 90 days past due are referred for collection. If your account is forwarded to collections, an additional 40% will be added to your account to cover all expenses. If you are involved in a liability claim, the above stated policies apply. We are unable to wait for settlement by the involved parties.

I have read and understand the above stated credit/insurance policies. I accept ultimate responsibility for my account and the amount due for services rendered. I will do everything possible to assist in collecting from my insurance carrier, if applicable.

Child's Name

Responsible Party Signature

Date

Consent for Secure/Release of Information

Child's Name: _____ DOB: _____

Address: _____

I hereby authorize and request Little Works In Progress to secure and/or release medical, social, educational, and other clinical information regarding the child named above. I understand that this consent automatically expires one year from the date of signature. This authorization applies only to the following individuals/institutions: If not completed, no information will be released from our office.

Primary Care Physician: _____

Insurance Carrier: _____

School Name: _____

Parent: _____

Grandparent/other caregiver: _____

I hereby further direct that a copy of this authorization shall be deemed to be as valid as the original for all purposes authorized herein.

Signature: _____ Date: _____

Printed Name: _____

Relationship to child: _____