Let's Communicate, Inc.

204 Resource Lane
Winder, GA 30680
P: 678-963-0694; F: 888-547-4008

AUTHORIZATION FOR RELEASE OF INFORMATION

Child _____ DOB _____

Parent(s) _____

Mailing Address _____

_____

Phone # _____ Cell # _____

Authorization Given To:	**For Release of Information To:**
_____	_____
Agency	Person Requesting Information
_____	_____
Address	Address
_____	_____
City, State, Zip	City, State, Zip
_____	_____
Contact Person/Phone	Contact Person/Phone

Please Forward the Following Information (Checked Only):

- o Physicians Referrals
- o Speech/Language Diagnostic Evaluation Report(s)
- o Treatment Plan(s)
- o Speech/Language Progress Report(s), if applicable
- o Medical Records with special instructions, if applicable
- o Special Education IEP (Individualized Education Plan) Protocol

It was fully explained to me why this information was needed.

Parent Signature Date

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION:

I hereby request that payment of authorized Medicaid, Peachcare for Kids and/or health insurance plan benefits be made on my behalf to **Let's Communicate, Inc.** for therapy services provided. I authorize **Let's Communicate, Inc.** to release to my third party payer / insurer and / or to the Health Care Financing Administration and its agents, if necessary, any medical information needed to determine the benefits payable for related services. I understand that I will be personally responsible for any amount denied, or any remaining amount owed for services partially covered by my third party payer / insurer.

Patient/Guardian _____ Date _____

FINANCIAL POLICY:

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment or your estimated share be made upon receipt of your billing. If your insurance carrier does not remit payment within sixty days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining up to the current Medicaid reimbursement rate.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to us by forwarding the actual payment with explanation of benefits to our office, with endorsement made and reassigned to provider.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

I have read the above information and understand my responsibility for the payment of my account.

Patient/Guardian _____ Date: _____

ATTENDANCE POLICY:

We are happy to work with you and your child; however, because our schedule and billing are dependent on successful appointments, it has become necessary to establish the following attendance policy. We will continue to schedule your weekly appointments for speech and/or occupational therapy unless you consecutively miss two appointments without contacting us to cancel within 24 hours of the appointment. We understand emergencies and are happy to work with you to reschedule when necessary but ask that you let us know as soon as possible so that we can adjust our schedule.

I have read the above information and understand my responsibility for attendance at scheduled appointments.

Patient/Guardian_____ Date:_____

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION DATE _____

I authorize **Let's Communicate, Inc.** to use and disclose my medical information for the purposes of Treatment, Payment and Health Care Operations.*****

> ***Treatment** includes activities performed by a health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician.
>
> ***Payment** includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.
>
> ***Health Care Operations** includes the necessary administrative and business functions of our office.

I further authorize **Let's Communicate, Inc.** to use and disclose the following specific health and medical information for the below listed purpose(s):

Specific medical information consisting of: therapy evaluation, assessment, progress notes and transition meetings

For the specific purpose of: collaboration of services (Speech, Physical and Occupational Therapists, BCW Service Coordinators & Staff, Physicians)

I understand that I have the right to revoke this Consent provided that I do so <u>in writing</u>, except to the extent that Let's Communicate, Inc. has already used or disclosed the information in reliance on this Consent.

_____ _____
Signature of Patient Date

_____ _____
Signature of Person Authorized by Law Date

If **Let's Communicate, Inc.** is requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this Authorization; and
- We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.
Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.
You may review **Let's Communicate, Inc.'s** "Notice Of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent.
Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the Notice in the upper right hand corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon your request.
As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by **Let's Communicate, Inc.** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Let's Communicate, Inc.**

I understand that diagnosis or treatment of me by **Let's Communicate, Inc.** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. **Let's Communicate, Inc.** is not required to agree to the restrictions that I may request. However, if **Let's Communicate, Inc.** agrees to a restriction that I request, the restriction is binding on **Let's Communicate, Inc.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **Let's Communicate, Inc.** or **Let's Communicate, Inc.** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Let's Communicate, Inc.**'s Notice of Privacy Practices prior to signing this document.

The **Let's Communicate, Inc.**'s Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **Let's Communicate, Inc.**

The Notice of Privacy Practices for **Let's Communicate, Inc.** is also provided **in the Office Manager's office.**

This Notice of Privacy Practices also describes my rights and the duties of **Let's Communicate, Inc.** with respect to my protected health information.

Let's Communicate, Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by calling the **Let's Communicate, Inc.**'s office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of Patient or Personal Representative Date

_____
Description of Personal Representative's Authority

Cancellation/No Show Policy

This policy has been established to help us serve you better. In order to offer you the highest quality of therapy, regular attendance is crucial. We cannot reserve therapy time for clients who do not maintain consistent attendance.

We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case by case basis.

We require at least 24 hours notice, so that your appointment time can be reallocated to someone else or business matters. Late cancellations will be considered as a **No Show**. Therapy sessions canceled less than 24 hours in advance due to illness will be given consideration. Your therapist will work with you to reschedule a canceled appointment when possible.

In the event of excessive cancellations or **No Shows**, we will discuss the need to re-evaluate the child's therapy schedule. If there are 3 **No Shows**, a letter will be mailed to you and the doctor stating that your child has been discharged from therapy.

Cancellation:
A **Cancellation** is any appointment cancelled at least 24 hours in advance or before 8am on the day of the appointment. For planned absences, we request that you notify your therapist as soon as you are aware of the need to cancel.

No Shows:
A **No Show** is any missed appointment without a phone call to cancel as defined above. If you fail to cancel an appointment, we cannot use that time for another client.

I have read and agree to comply with this Attendance & Cancellation Policy.

_____ _____

Parent/Caregiver Signature Date

LET'S COMMUNICATE
Pediatric Therapy Services
204 Resource Lane
Winder, Georgia 30680
Phone 678-963-0694

FAMILY AND MEDICAL HISTORY FORM

PART 1 - GENERAL INFORMATION

CHILD'S FULL NAME: _____ DATE OF BIRTH: _____

HOME ADDRESS: _____

HOME PHONE: _____

PHYSICIAN'S NAME: _____ PHONE #: _____

COMPOSITION OF FAMILY IN WHICH CHILD CURRENTLY RESIDES (Primary Caregivers)

FATHER'S NAME: _____ DATE OF BIRTH: _____

SOCIAL SECURITY #: _____ OCCUPATION: _____

RELATIONSHIP TO CHILD (please circle one): Biological Adoptive Step Foster Other

MOTHER'S NAME: _____ DATE OF BIRTH: _____

SOCIAL SECURITY #: _____ OCCUPATION: _____

RELATIONSHIP TO CHILD (please circle one): Biological Adoptive Step Foster Other

BIOLOGICAL PARENT INFORMATION (if not current caregiver or different from above):

FATHER'S/MOTHER'S NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

PHONE #: _____

IF BOTH PRIMARY CAREGIVERS WORK, WHO CARES FOR THE CHILD?_____

ADDRESS: _____

PHONE#: _____ WHEN IS CHILD IN THIS CHILDCARE? _____

OTHER PERSONS LIVING IN THIS CHILD'S HOUSEHOLD:

NAME SEX AGE RELATIONSHIP TO CHILD

FAMILY STRESSORS (please note/explain if any of the following stressful events happened in the last 12 months):

ITEM	NO	YES	EVENT	EXPLANATION
1			Marital separations/divorce	
2			Death in the family	
3			Financial crisis	
4			Job change/difficulties	
5			School problems	
6			Legal problems	
7			Medical problems	
8			Household move	
9			Extended separation from parents	
10			Other stressful event	

PART 2: PREGNANCY AND BIRTH HISTORY

Please list all pregnancies in order (including this child, miscarriages, terminations or deceased):

PREGNANCY #	BIRTH WEIGHT	ANY DELVIERY, HEALTH OR DEVELOPMENTAL PROBLEMS	FATHER
1			
2			
3			
4			
5			
6			

PRENATAL HISTORY:

1. Did you have any problems getting pregnant? Please describe: _____

2. In what month did you begin prenatal care? _____

3. Please list all over the counter medications taken during this pregnancy and when (eg. vitamins, antacids, cold medications, aspirin etc): _____

4. Please list any cigarettes, caffeine, street drugs taken (how much a day and when in pregnancy): _____

5. Please list all prescription medications taken (name, dosage and from when to when): _____

_____

6. Please give in pounds, the amount of total weight lost and/or gained during this pregnancy:_____

7. Did you have any of the following events occur during this pregnancy? Please indicate by placing a checkmark in the "no" or "yes" column and explain (what month, why, what, what occurred, how treated etc):

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Allergies or asthma	
2			Anemia	
3			Diabetes/blood sugar problems	
4			Edema (swelling, water retention)	
5			Excessive vomiting	
6			Headaches/migraines	
7			Heart disease	
8			Kidney disease	
9			Pre-eclampsia	
10			Rh negative	
11			Toxemia	
12			Toxin exposure	
13			Accidents	
14			Bleeding/spotting	
15			Blood transfusions	
16			Cervical incompetence	
17			Infections (bladder or genital)	
18			Infections (other)	
19			Pre-term labor	
20			Uterine or uterine fluid problems	
21			Other physical injury	
22			Other not specified problem	

BIRTH HISTORY (for the child being evaluated):

1. Hospital where born + city + state: _____

2. Physician's Name: _____

3. Gestational Age at time of delivery (or # weeks early or late): _____

4. Length of Labor (in hours)? _____ Length of membrane rupture? _____

5. Any type of labor stimulation and what was used? _____

6. Any type of pain medication or anesthesia used during delivery (name, type, amount if known)?

Pain relief _____ Anti-vomiting _____

Sedation _____ Anesthesia _____

7. What type of delivery (please circle)? Vaginal Cesarean Section = elective or emergency

Presentation: Head, Face, Breech, Transverse Reason for C-section _____

Assistance: Forceps, Vacuum, other _____

8. Did you experience any of the following problems during the labor/delivery? Please indicate by placing a checkmark in the "no" or "yes" column and explain (why, what occurred, how treated etc):

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			MATERNAL infection	
2			Low/high red/white blood cell count	
3			Pelvis or cervical problems	
4			Placenta problems	
5			Dysfunctional labor	
6			BABY had the cord around the neck	
7			Cord problems (knots, prolapsed, compression)	
8			Baby had very low or high heart rate	
9			Baby had heart rate decelerations	
10			Fetal distress was noted	
11			Meconium was noted	

9. How soon after the delivery did you see your baby _____

10. What was the baby's APGAR scores? 1 minute _____ 5 minute _____

11. What was the baby's Birth Weight? _____ Birth Length _____

12. Number of Days spent in the nursery? _____NICU or Newborn Nursery? _____

13. What was the condition of your infant while in the nursery? Please indicate by placing a checkmark in the "no" or "yes" column and explain (what month, why, what, what occurred, how treated etc):

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Was blue/cyanotic at birth	
2			Required stimulation to breathe	
3			Required oxygen at birth	How much/what type?
4			Required resuscitation	
5			Was considered small for gestational age	
6			Had tremoring or seizures	Which/for how long?
7			Very low tone	
8			Brain hemorrhage	

9			Anemia and/or transfusions	Which/how many times?
10			Jaundice (yellow)	How much/how treated?
11			Had bruising	
12			Rh incompatibility problems	
13			Infections	
14			Congenital birth defects	
15			Aspiration (meconium or fluid)	Which/how treated?
16			Respiratory distress signs or syndrome	
17			Needed ventilation	What type/how long?
18			Choking or vomiting episodes	
19			Tube feedings	
20			Needed medications	

NUTRITIONAL HISTORY

Describe your child's feedings briefly from birth, noting any difficulties (breast/bottle fed, weaned when, introduced solids/table foods, colic/food allergies, growth/nutrition problems, feeding problems _____

_____

_____

_____

_____

_____

_____

PART 3: MEDICAL HISTORY OF CHILD

It is very important to have as complete a medical history for your child as possible. Please fill out the grid below, making sure you include an explanation for any question answered "yes". In your explanation, please include your child's age(s) if relevant, any diagnoses made, and any treatments that have occurred.

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Frequent Colds/Respiratory Illness	
2			Frequent Strep throat/sore throat	
3			Frequent Ear Infections (?tubes)	
4			Birth defect/genetic disorder	
5			Lung condition/respiratory disorder	
6			Allergies or asthma	
7			Heart condition	
8			Anemia/blood disorder	
9			Kidney/Renal disorder	
10			Urinary problems/infections	
11			Hormonal problem	
12			Muscle disorder/muscle problem	

13			Joint or bone problems	
14			Fractured bones	
15			Skin disorder/skin problems (eczema)	
16			Visual disorder/vision problems	
17			Eye infections	
18			Neurological disorder	
19			Seizures or convulsions	
20			Stomach disorder/stomach pain	
21			Vomiting/digestion problems	
22			Failure to gain weight/feeding problems	
23			Constipation/diarrhea problems	
24			Dehydration episodes	
25			Hearing Loss/Ear disorder	
26			Significant accidents	
27			Head injuries or concussions	
28			Ingestion of toxins, poisons, foreign objects	
29			Major medical procedures (detail below)	
30			Chronic medications (for what? when?)	
31			Any major childhood illness (pox, croup, measles, mumps, meningitis etc)	

HOSPITALIZATIONS AND/OR SURGERIES:

List the dates of any hospitalizations your child has had and the reason. List the dates of any surgeries your child has had and the reasons.

1. _____ 3. _____

2. _____ 4. _____

PRESENT HEALTH STATUS: Most recent Height = _____ Weight = _____Date: _____

Please note any illnesses for which your child is currently being treated, including their Current Medications:_____

_____

_____

PART 4: DEVELOPMENTAL HISTORY

We would like to have information about your child's developmental milestones. Indicate the age when your child first did each of the following INDEPENDENTLY. If you can not recall/find a specific age, please mark whether you believe your child accomplished the milestone early, on time or late. If your child has not yet achieved the milestone, write NA in the age column. Please also rate your estimation of the quality of your child's skills.

MILESTONE	AGE	EARLY	ON TIME	LATE		GOOD/FAIR	POOR
Smiled							
Held head up							
Rolled over							

Reached for an object actively							
Transferred object between hands							
Sat unsupported							
Crawled							
Stood alone							
Walked by self							
Said first words							
Threw objects actively							
Ran by self							
Followed simple 1 step directions							
Said 2-3 phrases							
Ate unaided with a spoon/fork							
Dressed self							
Rode bicycle without training wheels							
Caught a thrown object							
Demonstrated handedness (which?)							
Knew colors							
Counted to 5							
Knew alphabet							
Bladder trained - days							
Bladder trained - nights							
Bowel trained							

Part 4: Developmental History (continued)

1. Do you feel your child was "faster" or "slower" than his/her peers in any other way? Please explain _____

_____

2. If your child is in school, please describe any difficulties or strengths in reading, writing or spelling: _____

_____

3. Name of previously attended school(s):_____ Grades(s): _____

_____ _____

4. Name of current school: _____ Grade: _____

Address: _____ Phone: _____

Any special educations services (which, when)?_____

Teacher:_____

Describe any other concerns shared by the teacher: _____

5. Has your Child ever been in therapy (eg. Occupational Therapy, Speech Therapy, psychotherapy, Physical Therapy)? Please indicate what type and when, and who the provider was.

Start date – End date	Type of Therapy	Provider Name	Provider contact information

6. Has your child had problems with any of the following (beyond expected for child's age):

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Sleeping problems	
2			Bed wetting	
3			Drooling	
4			Thumb sucking	
5			Temper tantrums	
6			Head banging	
7			Breath holding	
ITEM	NO	YES	DESCRIPTION	EXPLANATION
8			Aggression/destructiveness	
9			Nervous habits (nail biting etc)	
10			Masturbation	
11			Fire play or cruelty to animals	
12			Major mood swings	
13			Under or over reactive to sounds	
14			Under or over reactive to clothing	
15			Under or over reactive to taste	
16			Under or over reactive to smell	
17			Any unusual fears?	

PART 5: FAMILY MEDICAL HISTORY

Are there any of the following medical problems on either side of the child's BIOLOGICAL parents' families? If YES, please indicate on which side of the family, MOTHER or FATHER and explain WHO this is in relation to the CHILD. Please also explain if medications, surgery or hospitalizations were needed.

ITEM	NO	YES	DESCRIPTION	MOTHER Or FATHER'S SIDE ?	WHO? (as related to your child)	EXPLANATION
1			Birth defects/Congenital disorder			
2			Neurological disorder or seizures (eg. Alzheimer's, Parkinson's)			
3			Respiratory disease or tuberculosis (eg. Asthma, COPD)			
4			Hormonal or Gland disorder (eg. Hypothyroidism, pituitary tumor)			
5			Allergies - food or environmental (specify which type and for whom)			
6			Diabetes (Type 1 or 2)			
7			Stomach disease/disorder/problems (eg. Reflux, Colitis, Chron's, Celiac)			
8			Senses problems - vision, hearing, touch, taste, smell, balance			
9			Swallowing or feeding problems (eg. described as picky eater as child, esophageal strictures)			
10			Attentional/learning problems			
11			Hyperactivity			
12			Developmental therapy (eg. Speech therapy, Physical therapy)			
13			Alcohol/drug problems			
14			Psychological/nervous issues			