Alaska Speech & Hearing Clinic

2401 E. 42nd Ave. Ste #101
Anchorage, AK 99508-5228
Phone: (907) 562-4550
Fax: (907) 562-4554
www.akspeechclinic.com

Intake Form: Child

Legal name First____________________ MI___ Last___________________
Preferred/nickname: First____________________ MI___ Last ___________________
Date of Birth______________________ Social Security # ________________________
Mailing Address_______________________ City ____________ State____ Zip______
Physical Address_______________________ City ____________ State____ Zip______
Home Phone ___________ Parent Work Phone ___________ Parent Cell Phone _____
Parent Email Address____

Primary Physician

Name: _______________________ Address: ___________________________________
Phone: _______________________ Clinic name:_________________________________

SERVICES TO BE PROVIDED

Speech / Language Therapy ______ Audiology ______
Reason for Today's Visit/ Concerns: ____
Referral Source: ___Physician ____Friend ___ Insurance Company ___ Advertisement ___other
Please name:____

PARENT INFORMATION

Mother's Name ____
Address ____
Patient Lives with: YES NO
Home Phone ____________________ Work Phone _________________ Cell Phone __________
Mother's preferred contact (8:00am-6:00pm): Cell phone__ Home phone___ Work phone___
Name of Employer ____
Address ____City/State/Zip__________________
OK to Call (8:00am-6:00pm)? YES NO Best Time to Call____________________________
Parenting Status: Natural Adoptive Foster Other:

Father's Name ____
Address ____
Patient Lives with: YES NO
Home Phone ____________________ Work Phone _________________ Cell Phone __________
Father's preferred contact (8:00am-6:00pm): Cell phone__ Home phone___ Work phone___
Name of Employer ____
Address ____City/State/Zip__________________
OK to Call (8:00am-6:00pm)? YES NO Best Time to Call____________________________
Parenting Status: Natural Adoptive Foster Other:

EMERGENCY CONTACT
Name ________________________Relationship to Patient:_____________________________
Address____ City/State/Zip ___________________
Home Phone ______________________ Work Phone ______________ Cell Phone __________

ADDITIONAL CONTACTS
Legal Guardian (if not parent)/ Other/ Name:____
Home Phone ______________________ Work Phone ______________ Cell Phone __________
Address____ City/State/Zip ___________________

INSURANCE INFORMATION
PLEASE LIST ALL INSURANCE COMPANIES EVEN IF THEY WILL NOT COVER
Primary Insurance (attach copy of insurance card):
Insurance Company Name ________________________________Eligibility dates:___________
Insured's Name ______________________________ Phone _____________________________
Address ____________________________ City/State/Zip_______________________________
Date of Birth ________________________ Social Security # ____________________________
Policy Number ______________________ Group Number ____________________________
Relationship Self Spouse Child Other:
Insured / Subscriber Employer ____
Sex: Male Female Date of Birth ____
Is a referral / authorization required? Yes No (If yes, attach copy)

Secondary Insurance (attach copy of insurance card):
Insurance Company Name ________________________________Eligibility dates:___________
Insured's Name ______________________________ Phone _____________________________
Address ____________________________ City/State/Zip_______________________________
Date of Birth ________________________ Social Security # ____________________________
Policy Number ______________________ Group Number ____________________________
Relationship Self Spouse Child Other:
Insured / Subscriber Employer ____
Sex: Male Female Date of Birth ____
Is a referral / authorization required? Yes No (If yes, attach copy)

Tertiary Insurance (attach copy of insurance card):
Insurance Company Name ________________________________Eligibility dates:___________
Insured's Name ______________________________ Phone _____________________________
Address ____________________________ City/State/Zip_______________________________
Date of Birth ________________________ Social Security # ____________________________
Policy Number ______________________ Group Number ____________________________
Relationship Self Spouse Child Other:
Insured / Subscriber Employer ____
Sex: Male Female Date of Birth ____
Is a referral / authorization required? Yes No (If yes, attach copy)

____
Signature of Patient (or parent/legal guardian if under 18):

____
Printed name *for* Please print patient name

Date Signed __________________________

Please continue the child's registration process and complete the HIPAA Privacy Notice, Release of Information, and Medical History below. Thank you!

Alaska Speech & Hearing Clinic

2401 E. 42nd Ave. Ste #101
Anchorage, AK 99508-5228
Phone: (907) 562-4550
Fax: (907) 562-4554
www.akspeechclinic.com

Patient or Child's Name:____ Date of Birth:________________
Please Print

CONSENT FOR EVALUATION

___________ (Initial) I give permission for my child to be evaluated and treated by Alaska Speech and Hearing Clinic (ASHC). The information obtained during the evaluation is confidential and will only be shared per our privacy practices.

___________(Initial) I have received a copy of or otherwise read ASHC's Notice of Privacy Practices.

RESPONSIBILITY FOR PAYMENT/AUTHORIZATION TO BILL INSURANCE

_________(Initial) Alaska Speech and Hearing Clinic has agreed to submit bills directly to the insurance provider. Please note that we will only submit our bills twice and then we will bill the family. The patient/family must pay for all deductibles and co-payments at time of service. It is the responsibility of the family to pay all outstanding bills not covered by their insurance based on policy coverage of speech and language therapy and audiology services. I authorize ASHC to bill my insurance carrier directly and agree to be responsible for all amounts not covered by the insurance company (exclusion: Tricare/Medicaid). I also agree to allow ASHC to release any medical records requested by the insurance carrier for payment of service. I understand that my insurance is billed for me as a courtesy. I am responsible for furnishing all insurance information and any changes in policy or coverage. All insurance policies must be listed whether they have coverage for our services or not. Bills not paid in a reasonable length of time could be sent to a collection agency. Patients will then be responsible for not only their balances due but also all collection agency, attorney and court fees. If your insurance company denies payment, your entire balance is due at once. Please check your EOB's when they arrive in the mail from your insurance companies. Please note that bills sent to the collection agency could negatively affect your credit rating. We are not a bank and unable to extend credit. Interest will be added to account over 60 days past due.

NO SHOW/LATE POLICY

________(Initial) Due to a growing number of missed appointments without prior cancellation or being excessively late for appointments (more than 15 minutes) we now bill the patient/parents for any missed appointment without prior cancellation (At least 8 hours in advance) unless unexpected medical (i.e. sick child). If a patient/family shows up more than 15 minutes late without prior notification, we will not see the child and the patient/family will be responsible for the full price of the missed appointment. We make every effort to see patients on time and lateness impacts our schedule for the remainder of the day. The charge will be the full price of the scheduled appointment.

SICK PATIENTS

_________(Initial) We see many children throughout the day who are medically fragile. We would appreciate your consideration before coming to the clinic if you or your child are not feeling well. A cold or flu bug for one child may be a simple illness but to another could create a major medical problem. If your child is showing signs of illness please call and cancel your appointment. Signs of illness/ reasons to stay home include: fever, severe coughing, trouble breathing, yellow skin or eyes, pinkeye/conjunctivitis, unusual spots or rashes, infected skin, unusual behavior, diarrhea, sore throat, trouble swallowing, headache, fever, loss of appetite, scabies, lice, and yellow or green discharge from the nose. If you cannot reach a person in the clinic, please leave us a message. If you have any questions whether or not you or your child should be seen, please do not hesitate to call and ask.

RELEASE OF INFORMATION

I grant permission for ASHC to release and receive medial records, evaluations, progress notes, plans of care and other information with the following people or agencies:

____
____
____
____

I have read and understand fully the contents of the above initialed agreements and releases as shown and agreed on by my signature here below.

____
Patient/Guardian Signature Date

____
Please Print Full Name

Alaska Speech & Hearing Clinic

2401 E. 42nd Ave. Ste #101
Anchorage, AK 99508-5228
Phone: (907) 562-4550
Fax: (907) 562-4554
www.akspeechclinic.com

Notice of Privacy Practices

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Alaska Speech and Hearing Clinic (ASHC) must protect the privacy of health information including: your name, Social Security number, address, telephone number, medical history, therapy evaluations, plan of care/treatment plan, progress notes, and discharge summaries. The purpose of this notice is to provide notification on how medical information about you or your child is collected, used, and disclosed and the procedures required for you to gain access to this information. This notice will be effective beginning April 1, 2003 and will be in effect until it is replaced. We collect health information from you and your child, other providers (i.e.: occupational therapists, physicians) and agencies. We will not collect information without a release of information from the patient or family. All providers or agencies will need to be listed on the release of information in order for us to collect information.

PATIENT ACCESS

We need to collect information to help us treat your child. We understand that the information that we collect is personal. At ASHC we are committed to protecting our patient's privacy and keeping their therapy information private. New regulations require that ASHC keep your health care information private. Upon contacting our clinic, you will be asked to give consent for evaluation and treatment. Once you have signed this form, protected health information can be used by therapist and office staff, contracted therapists and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may be used and disclosed to pay your evaluation and therapy bills and in the operation of our clinic. Here are examples of how protected health/therapy information can be used once you have signed our consent form.

HOW CAN WE USE AND DISCLOSE PERSONAL HEALTH INFORMATION

We can use personal health information for the following purposes without a release from the patient or guardian. All other purposes require written permission.

TREATMENT: We will use protected health information to evaluate and treat speech, language, audiology and feeding issues. This includes disclosing protected health information with other speech, occupational, or physical therapists, physicians, nurses, psychologists or others involved in your care as it is related to your speech, language or feeding treatment. We have you complete a release of information form giving us permission to disclose private health information.

PAYMENT: Protected health information is often required to obtain payment for health services. We bill insurance as a courtesy to our patients. Insurance companies often need copies of evaluations, plan of cares and progress notes to assess eligibility for services rendered and whether treatment/therapy is medically necessary. We will send these records upon request from the insurance company.

HEALTHCARE OPERATIONS: We may use or disclose your protected health information on a need-basis to complete business activities at Alaska Speech and Hearing Clinic. These activities might include: qualitative assessment, employee review, training, and licensing. Examples of using protected health information is on the use of sign-in sheet at the front desk, using your name to call you to your appointment, contracted billing services, or calling to remind family of appointments. All individuals who might see or have access to your protected health information through our clinic for purposes of billing or transcription services will have signed a written contract agreeing to safeguard all protected and confidential health information.

REQUIRED BY LAW

We can use or disclose your protected health information when required by law. Only the relevant information will be provided and only upon written request. You will be notified of any request.

PUBLIC HEALTH

We may use or disclose your protected health information for the purpose of controlling disease, injury or disability.

ABUSE OR NEGLECT

We may disclose your protected health information to a public health authority if we suspect or observe child abuse or neglect. We will follow federal and state laws.

LEGAL PROCEEDINGS/LAW ENFORCEMENT

We may disclose your protected health information if a subpoena or discovery request is received. Only information requested will be provided.

ALL other uses of your protected health information will only be disclosed or shared after receiving written authorization by you. You can revoke this authorization, at any time, in writing.

PATIENT RIGHTS

Patients have the right to inspect and amend their medical records. You have the right to review your medical records in our office. To review your health records, you must submit a written request to review your records. We must be given 48 hours (excluding weekends) to pull all records. If you feel that there are errors in your health records, you can put in a request that the information be corrected or added to the records. You can request a list of where this information was sent and a new copy can be sent with updated information. We have the right to add that we are not in agreement with the added/changed information. You have a right to see who has been given copies of your records or whom information has been shared with (name and agency). We also may add a reasonable fee if requested copies and mail fees are excessive.

You have the right to request restriction of your protected health information to any or all individuals. We will not be able to see your child without a signed plan of care and ability to collect payment from insurance or family. All other individuals or agencies can be restricted upon written request. You must provide in writing specific restriction requested and whom this restriction will apply. It is your responsibility to request a restriction or limitation on sharing restricted health information regarding your treatment, payment or health care operation activities. Please see the office manager or Lisa Owens for a restriction request.

All health information will be shared with you via U.S. mail or personally in the office. If you would like information shared in a different way, please let us know in writing. You have the right to tell us how you would like to receive information. This request should be made in writing if you would not like to receive information at a specific location.

You have the right to receive a copy of this notice. We will ask that you read through the notice and sign it for our records. Additional copies are available from the front desk.

Questions or Comments

If you have any questions or feel that a violation of your privacy rights has happened, please contact Lisa Owens to obtain information on your rights or the complaint process. You can also contact the Secretary of Health and Human Services if you feel that your concern cannot be adequately addressed through our office. We will make all attempts to help resolve any issue. We can be reached at (907) 562-4550 or Fax (907) 562-4554

Patient Signature   Date
____

Print Name
____

If you have any questions please contact Lisa Owens, M.A., CCC-SLP/A

This Notice was developed on March 1, 2003 and will be effective as of April 1, 2003.

Alaska Speech & Hearing Clinic

2401 E. 42nd Ave. Ste #101
Anchorage, AK 99508-5228
Phone: (907) 562-4550
Fax: (907) 562-4554
www.akspeechclinic.com

MEDICAL HISTORY FORM

Today's date: ____________________________

Patient's Legal name First___________________ MI___ Last__________________
Preferred/nickname: First___________________ MI___ Last __________________
Date of Birth_____________________ Social Security # _______________________
Mailing Address______________________ City ____________ State____ Zip______
Physical Address______________________ City ____________ State____ Zip______

PARENT'S CONCERNS

Reason for today's evaluation____
Previous Diagnosis, if any: ____

Please check any areas of development that you may have concerns about:
O Attention O Touch O Speech/Language O Motivation
O Eating/feeding O Nutrition O Temper tantrums O Ability to calm themselves O
Hearing O Play O Vision O Movement
O Behavior O Sleeping O Weight/growth O Hand use
O Mobility O Other: ____

MEDICAL HISTORY

Pregnancy proceeded: Normally Any complications (please list): ________________
____

Please circle any that apply:
Gestational diabetes Toxemia Pre-eclampsia Eclampsia Multiple births Substance exposure Positive for strep B Positive for cytomegalovirus (CMV)
Premature labor Other: Length of pregnancy: ____________Weeks
Prenatal care was: Received ____ Not received______
Mother's age at time of birth: ___________ years ______ months
Length of hospital stay: Days
Delivery was: Vaginal C-Section Emergency C-Section
Complications during delivery: Premature rupture of membranes Breech presentation None
Placenta previa Abruptio placenta Use of forceps Uterine rupture
Transverse presentation Prolapsed cord Umbilical cord wrapped around the neck
Other: ____
Child's birth weight:__Lbs.__oz. Birth length: ____ inches
Apgars: 1 minute __________ 5 minute __________ 10 minute ___________

Were there significant complications following the birth: Yes No

Please circle any significant birth complications: none

Meconium aspiration Respiratory distress syndrome Respiratory stridor

Neonatal hypoxia Club foot VP shunt PDA

Positive dependency Failure to thrive Cytomegalovirus Cleft lip and/or Palate

Respiratory syncytial virus (RSV) Hyperbilirubinemia ECMO

Anemia of prematurity Retinopathy of prematurity (ROP) IVH Bleed Oxygen dependency

Brochopulmonary dyspasia (BPD)

Ventilator dependency Intrauterine growth retardation (IUGR) Other:

Diagnosed / suspected syndrome ____

Current Health Issues/ Concerns:

Chronic ear infections Sleep problems Traumatic brain injury (TBI)

Cerebral vascular accident (CVA) Anoxic brain injury

Asthma / respiratory Arteriovenous malformation (AVM)

Reflux Colic Constipation / diarrhea

Tube feeding Seizure disorder (date of last seizure _______________)

Allergies (please list): ____

Current medications ____

Homeopathy ____

Hearing tested YES NO Results ____

Date: (mo/yr) ________________________

Vision tested YES NO Results ____

Date: (mo/yr) _________________________

Specialists Seen:

Cardiologist	Allergist	Oncologist	Endocrinologist
Orthopedic Surgeon	ENT	Pediatrician	General Surgeon
Physiatrist	Hand Surgeon	Podiatrist	Internal Medicine
Rheumatologist	Neurologist	Thoracic Surgeon	Neuro-Surgeon
Urologist	Psychiatrist	Audiologist	Gastroenterologist
Opthamologist	Nephrologist	Geneticist	Developmental Medicine

Name of specialist(s) currently working with child:

____

____

____

Please indicate any of the following:

Swallow Study (Date and place)____

BAER (Date and place)____

MRI/CT Scan/X-RAY (Date and place)____

List any previous surgeries: (indicate age at time of surgery)

Age: Surgery:

Age: Surgery:

DEVELOPMENTAL HISTORY

MOTOR, SENSORY, PLAY

At what age did your child: Age (optional if child is over 10 years of age)

Hold head up alone
Roll over
Sit alone without support
Crawl / creep alone
Pull self to standing position
Walk unaided
Grab toy
How does your child get around at home?
Does child fall or lose balance easily? Yes No
Is your child
Right-handed Left-handed Neither
Does your child visually look at people and/or toys? Yes No
Does your child show a negative response when touched or when touching other objects? Yes No
Does your child enjoy movement such as swinging or roughhousing? Yes No
What are your child's favorite toys and/or play activities?
Does your child play and/or participate in leisure activities daily? Yes No
Is your child involved in community programs (school, special rec., scouting, etc.)? Yes No

FEEDING, SPEECH and LANGUAGE

Does your child have any feeding problems? Yes No
Please describe:
When did your child: Age (optional if child is over 10 years of age)
Stop using a bottle
Name familiar objects
Stop using a pacifier Use two-word combinations
Begin using a cup, sippy cup, straw
Begin eating - Baby food Finger Food Table Food
List Food Preferences Dislikes
Check areas of difficulty, if any:
Chewing Swallowing Drooling
Understanding words Communicating needs
How does your child communicate his/her needs?
Verbal Communication: Non-verbal Communication: Vocalizations Facial expression Body language Single words Pointing / gestures Manual sign language Phrases Eye gaze Sentences Augmentive Communication System (explain):
What were your child's first words?
Do most people understand your child's speech? Yes No
Does your child understand instructions? Yes No
Please check any of the following that may currently describe your child: Affectionate Motivated Difficult to Comfort Playful Cautious Aggressive Curious Fearful Shy Passive Active Demanding Fearless Stubborn Fussy Calm Distractible Persistent Withdrawn Insecure

School History

If your child is in school, what grade: Where:
Does your child have an IEP from school? Yes No
(Please include a copy of the most recent IEP with this intake packet)
Has your child had a psychological or neuropsychological evaluation completed? Yes No
(Please include a copy of the most recent psychological or neurological evaluation)

Therapy History

Has your child ever received any of the following services? YES NO

__Physical Therapy Individual Group	Location Dates Therapist/Provider
__Occupational Therapy Individual Group	Location Dates Therapist/Provider
__Speech / Language Therapy Individual Group	Location Dates Therapist/Provider
__Social Work Individual Group	Location Dates Therapist/Provider
__Assistive Technology	Location Dates Therapist/Provider
__Nutrition	Therapist/Provider
__Vision Therapy	Location Dates Therapist/Provider
__Audiology	Location Dates Audiologist
__Behavior Therapy	Location Dates Therapist/Provider
__Developmental Therapy	Location Dates Therapist/Provider