PEDIATRIC REGISTRATION FORM

(Please Print)

Today's date:			Email:		
PATIENT INFORMATION					
Patient's last name: First: Middle:			Accompanied By:		
Is this their legal name? ❑ Yes ❑ No	If not, what is their legal name?	(Nickname):	Birth date: / /	Age:	Sex: ❑ Other ❑ Male ❑ Female
Street address:		Cell phone no.:	Home phone no.: ( )		
Apartment/Unit Number:	City:	State:	ZIP Code:		
Parent/Guardians Names:	Pediatrician:		Pediatrician's phone no.: ( )		

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Speech Clinic ❑ Other

Other family members seen here:

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Required by the Health Insurance Portability and Accountability Act ---- 45 CFR Parts 160 and 164)

1. I hereby authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

2. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

3. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

4. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the clinic. I understand that I am financially responsible for any balance. I also authorize Autumn Oak Speech, Voice, Balance, and Hearing or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

PATIENT HIPAA CONSENT FORM / NOTICES OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name: _____

With my consent and signature, Autumn Oak Speech, Voice, and Hearing may use and disclose protected health information about me to:

1. Carry out treatment, payment, and healthcare operations (services).
2. Call my home or other designated locations and leave a message on voice mail in reference to any items (i.e., appointment reminders, insurance items, references to clinical care of laboratory results, etc.) that will assist in the practice of medical care for me.
3. Mail to my home or other designated address any item (i.e., appointment reminder cards, patient financial statements, etc.) that will assist in practice of medical care from me. Such correspondence is to be marked personal and confidential.
4. Send or transmit email to any location provided by me for all above similar items and purposes.
5. To use and/or disclose protected health information about me to/with third parties involved in my care. Such parties may include, but are not limited to, insurance companies, hospitals, specialty physicians, and laboratory personnel. I may specifically describe the type of information (i.e., dates of services, level of detail, origin of information, etc.) subject to disclosure and may revoke this permission at a time and date chosen by me. By providing a written statement to the privacy office Autumn Oak Speech, Voice, and Hearing, I may revoke this permission; however, Autumn Oak Speech, Voice, and Hearing may decline to provide further treatment to me. Autumn Oak Speech, Voice, and Hearing may also decline further treatment to me should my restrictions on the type of third-party information, in the center's opinion, impede medical care of me.

I have the right to review the Notice of Privacy Practice Manual of Autumn Oak Speech, Voice, and Hearing. Autumn Oak Speech, Voice, and Hearing may revise its manual and procedures at any time deemed necessary, and I may request from time to time, in writing, a copy of such changes, should these changes directly relate to my care.

I have the right to request that Autumn Oak Speech, Voice, and Hearing restrict how it uses or discloses my health information. However, as stated previously, Autumn Oak Speech, Voice, and Hearing is not required to agree to my restrictions. If Autumn Oak Speech, Voice, and Hearing accepts my restrictions, Autumn Oak Speech, Voice, and Hearing is then bound by the restriction in the agreement, setting forth the restricted information until providing me, in writing, a cessation of such agreement.

I may revoke this entire consent, in writing, at any time. If I do not sign this consent, or revoke this consent, Autumn Oak Speech, Voice, and Hearing, in their sole discretion, may decline further treatment for me.

The Federal HIPPA (Privacy Act) of 2001 was created to protect my health information. I understand this must be accomplished within the provisions and rules set up by Autumn Oak Speech, Voice, and Hearing to fulfill federal law. I may request to review the manual which spells out these provisions. Autumn Oak Speech, Voice, and Hearing will comply with this law to preserve privacy. If compliance with this law impedes the medical care of the patient, Autumn Oak Speech, Voice, and Hearing may decline to provide further care. Autumn Oak Speech, Voice, and Hearing will strive to provide information so that I may make an informed decision concerning the privacy of my medical information.

_____ _____

Patient/Guardian Signature Date

PEDIATRIC PATIENT MEDICAL & DEVELOPMENTAL HISTORY

(Please Print)

Patient's Name: _____ Date: _____

Why have you decided to evaluate your child's speech and language today?

- ☐ I feel s/he is not talking like other kids of same age
- ☐ Pediatrician recommended it
- ☐ Others have difficulty understanding my child when s/he talks
- ☐ Other reason: _____

HOME ENVIRONMENT

Who resides at home with the child? (Siblings (ages), mother, father, step-parents, grandparents, etc)

If another language is spoken, what language(s) is/are used in the home? _____

If more than one language, what percentage does your child speak of each language? _____

What percentage does your child hear of each language? _____

On average, how many hours of screen time is your child exposed to per day? _____

Any special circumstances?

☐ Parents divorced ☐ Joint physical custody ☐ Child adopted ☐ Other:_____

Any cultural or religious considerations for therapy? (Holiday celebrations, prohibitions, dietary restrictions etc)

HEALTH HISTORY

Any family history of speech and language issues? _____

Any family history of ADHD, Autism, Dyslexia, or other learning disability? _____

List any medications prescribed for your child: _____

Is there any history of any of the following? (***A tongue tie screening is recommended at the next dental appointment)***

☐ Allergies	☐ Occupational Therapy	☐ Premature Birth	☐ Early Intervention
☐ Hearing Loss	☐ Physical Therapy	☐ Seizures	☐ Behavior Therapy
☐ Speech Therapy	☐ Developmental Delay	☐ Vision Problems	☐ Tubes in ears
☐ Asthma	☐ Head Trauma	☐ Frequent Ear Infections	

Please provide further explanations for items checked above:

Please list known allergies:

Is your child diagnosed with any developmental or sensory disorders?

☐ ADHD ☐ Anxiety ☐ Autism ☐ Articulation Disorder

☐ Blind/ Visually Impaired ☐ Cerebral Palsy ☐ Deaf/ Hard of Hearing ☐ Degenerative Condition

☐ Dyslexia ☐ Down's Syndrome ☐ Fragile X Syndrome ☐ Intellectual Disability

☐ Language Disorder ☐ Learning Disorder ☐ Opposition Defiance Disorder ☐ Sensory Processing Disorder

☐ Social Communication Disorders ☐ Stuttering ☐ Other (List): _____

Are you concerned your child has any undiagnosed disorders? ☐ Yes ☐ No

If yes, explain:

_____

_____

Please list below any other illnesses, injuries, or surgeries (age and complications):

_____

_____

_____

When & where was the last time, your child had a hearing screening? _____

Were the results normal? ☐ Yes ☐ No. If no, please explain _____

Has your child had any speech and language testing? ☐ Yes ☐ No.

If yes, when/ where? _____

Has your child received any Speech and Language therapy? ☐ Yes ☐ No.

If yes, when/ where? _____

Does your child have an AAC Device? ☐ Yes ☐ No.

If yes, when/ where was it obtained? How do they use it currently?

_____

Any concerns about feeding/ swallowing difficulties? ☐ Yes ☐ No.

If yes, please describe: _____

PRENATAL & BIRTH HISTORY

Length of pregnancy _____ Birth Weight _____ Delivery complications ☐ Yes ☐ No

If yes, please elaborate _____

After birth, did the child have any difficulty with breathing, crying, sucking, jaundice, convulsions, blood incompatibility? ☐ Yes ☐ No

If yes, please elaborate _____

Does the child have any developmental delays besides speech? ☐ Yes ☐ No

If yes, please elaborate _____

Does the child speak yet? ☐ Yes ☐ No

First spoken word at what age: _____

Estimated number of spoken words to date: _____

How does your child indicate his/her needs/wants to you? _____

Please Describe your child's personality: _____

EDUCATION

How is your child currently educated? ☐ Caregiver-led at home ☐ Distance Learning ☐ Pre-school/ School

What language is your child taught in? _____

Name of School/Daycare & Grade: _____

Has your child ever been held back a grade? ☐ Yes ☐ No

Which subjects in school is your child on grade level for? ☐ Reading ☐ Math ☐ Science ☐ Social Studies

Does your child receive Special Education Services? ☐ Yes ☐ No

Does your child have an IEP or IFSP? ☐ Yes ☐ No If yes, what is it targeting? _____

COMMUNICATION & SOCIAL INTERATION

Does your child play well with other children? ☐ Yes ☐ No

Which of the following apply to your child?

☐ Cooperative

☐ Hyperactive

☐ Frequent self-stimulation (spinning, hand flapping, etc)

☐ Easily frustrated/ Impulsive

☐ Minimal eye contact

☐ Anxious

☐ Frequent tantrums

☐ Plays independently with others

☐ Inappropriate behavior

☐ Poor understanding of danger

Can your child clearly and appropriately communicate the following? Can your child use words/ symbols to communicate the following?

☐ Statements ☐ Questions ☐ Answers ☐ Wants ☐ Needs (ex: Help) ☐ Feelings ☐ Denials/ protests ☐ Discomfort

About how much of what your child says can you understand? ☐ Almost all ☐ Most ☐ Half ☐ Quarter or less

About how much could a stranger understand? ☐ Almost all ☐ Most ☐ Half ☐ Quarter or less

YOUR THOUGHTS

What is the main goal you wish to accomplish with Speech/ Language Therapy?

_____

_____

Do you have any other concerns you would like to share about your child?

_____

_____

OUR OFFICE POLICIES
(Please Print)

Patient's Name: _____ Date: _____

Thank you for choosing us as your provider. At Autumn Oak Speech, Voice, and Hearing, we recommend testing that is based off best practices and not what your insurance policy may or may not cover. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial and office policies, which we require you to read and sign prior to any treatment.

Insurance Benefits

You will be given an **ESTIMATED** amount due before services are rendered. The insurance plans accepted in our office have different percentages, deductibles, maximums, services covered, and varying fees that the plans will allow. Therefore, we cannot guarantee the exact amount of payments from insurance plans. Although we verify coverage, only an estimated amount is provided to the clinic.

We may accept assignment of benefits as a service to you. This means we will file a claim with the insurance company for their estimated portion of coverage. However, we are unable to bill your insurance unless you provide us with your current insurance information. The balance is your responsibility whether your insurance pays or not. Any variations or non-covered services are the patient's responsibility if services are rendered at the date of service. If we do accept the assignment of benefits from your insurance company, we require that your account is paid in full within 60 days of service.

Referrals

If a referral is required by your insurance carrier it is your responsibility to obtain the referral prior to your appointment.

Financial Policies

- Full payment is due at the time of service.
- There is a $45 service charge for all returned checks. If a check is returned, you will be notified as soon as possible.
- If your account goes over 90 days past due, it will be turned over to our collection agency.

Late or Missed Appointments

For our providers to see patients in a timely manner please arrive promptly for your appointment. As a courtesy our office will text all our patients the day before your appointment for confirmation.

If your family shares custody, Autumn Oak expects the parents to apprise each other of your child's schedule unless the court order is to the contrary. **(Initials: _____)**

If there is non-compliance of attendance (e.g., excessive cancellations monthly by our calculations) then all future appointments will be cancelled. If the patient misses 2 consecutive appointments with our office, any future appointments will be cancelled. In addition, a $45 charge will be made for each additional canceled or missed appointment unless a 24-hour notice is given. (Initials: _____)

Medical Records

Should you need a copy of the medical records, please allow 7-10 business days for completion. If records are being sent to another provider, a signed Consent to Release of Information form must be completed.

Use of Artificial Intelligence (AI)

Artificial intelligence (AI) may be lawfully utilized to assist in the recording, transcription, and documentation of patient care interactions, provided such use complies with applicable privacy legislation, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA). AI-driven systems can facilitate the accurate capture of clinical conversations, generate real-time transcripts, and automate the integration of pertinent details into electronic health records (EHRs), thereby enhancing both the accuracy and efficiency of clinical documentation. The deployment of such technologies are accompanied by appropriate consent protocols, robust data encryption, and secure storage practices to ensure the confidentiality, integrity, and lawful handling of protected health information (PHI).

Subpoena Policy

Autumn Oak Speech, Voice, and Hearing is a small business which survives on patient care and our regular daily operations. Due to the influx of subpoenas received, especially those served with less than a 24-hour notice, the following policy will be implemented immediately 11/29/2022:

If a provider or staff is subpoenaed to court for your custody case or any case requiring loss of scheduled patient care, the following charges will ensue: $300 charge per hour including travel time

If a provider or staff is served with a 24-hour or less subpoena notice, the following charges will ensue: $400 charge per hour including travel time

Autumn Oak Speech, Voice, and Hearing has the right to protect and maintain our patient care and the staff who are employed. Your signature below indicates that you are aware, informed, and responsible for these charges.

_____ _____

Patient/Guardian Signature Date

WAIVER OF LIABILITY FOR GYM USE

I understand and expressly agree that my use of this or any Autumn Oak Speech, Voice, and Hearing facility involves the risk of injury to me or my child whether caused by me or not. I understand that these risks can range from minor injuries to major injuries including death. In consideration of my participation in the activities and use the therapeutic/gym equipment, or services offered by Autumn Oak Speech, Voice, and Hearing, I understand and voluntarily accept full responsibility on my behalf and on my child's behalf for the risk of injury or loss arising out of or related to my use or my child's use of the facilities, therapeutic/gym equipment. I further agree that the Autumn Oak Speech, Voice, and Hearing, its affiliated companies and their respective officers, directors, employees, and volunteers (collectively "Autumn Oak Speech, Voice, and Hearing, Inc.") will not be liable for any injury; including, without limitation, personal, bodily, or mental injury, disability, death, economic loss, or any damage to me, my spouse or domestic partner, unborn children, heirs, or relatives, resulting from the negligent conduct or omission of Autumn Oak Speech, Voice, and Hearing or anyone acting on Autumn Oak Speech, Voice, and Hearing 's behalf whether related to therapy or not. Accordingly, to the fullest extent permitted by law, I do hereby forever release, waive and discharge Autumn Oak Speech, Voice, and Hearing from any and all claims, demands, injuries, damages, actions or causes of action against the Autumn Oak Speech, Voice, and Hearing. I further understand and acknowledge that Autumn Oak Speech, Voice, and Hearing does not manufacture equipment in its facilities, but purchases and/or leases equipment; therefore, Autumn Oak Speech, Voice, and Hearing will not be held liable for defective products. I agree to comply with the Autumn Oak Speech, Voice, and Hearing policies that may be communicated to me from time to time either in writing, through facility signage, or verbally. Autumn Oak Speech, Voice, and Hearing may, in its sole discretion, modify the policies without notice at any time. Autumn Oak Speech, Voice, and Hearing reserves the right to restrict patient's participation from therapeutic/gym equipment use, if equipment is improperly used. Understanding of this waiver is indicated by my signature below:

Print Child's Name_____

Print Parent's Name_____

Signature (Parent/guardian if under 18) _____

Date_____

In case of emergency, please contact

Name _____Phone_____


Autumn Oak