



Adult Case History Form

GENERAL INFORMATION:

Date: ___/___/___ Date of Birth: ___/___/___ Age: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work: (____) _____

Cell: (____) _____ E-mail: _____

Occupation: _____ Social Security Number ___ - ___ - ___

Employer: _____

Employer's Address: _____

How did you hear about us? _____

Primary Care Physician: _____ Phone: _____

Physician's Address: _____

Male/Female (circle one) Marital Status _____

Spouse's Name: _____

Children (Include Name, sex and ages): _____

Who lives in the home? _____

What languages do you speak? If more than one, which one is your primary language? _____

What was the highest grade level completed? Diploma or degree earned? _____

Describe the problem for which you are referred and your concern as it relates to your speech and language? _____

What do you think may have caused the problem? _____

When did you first notice the problem? _____

Has the problem changes since it was first noticed? If yes, please explain: _____

Have you seen any other speech-language specialists? Who and when? What were the results? _____

Have you seen any other specialist (physicians, psychologists, neurologists, etc.)? If yes, indicate the name, type of specialist, when you were seen, and the specialist's conclusions or suggestions: _____

Are there any other speech, language, learning, voice, or hearing problems in your family? If yes, please describe: _____

MEDICAL HISTORY:

Please check any of the following illnesses and conditions you may have had and please provide the approximate age:

___ Asthma	___ Frequent Colds	___ Noise Exposure
___ Chicken Pox	___ Hearing Loss	___ Otosclerosis
___ Convulsions	___ Ear Infections	___ Seizures
___ High Fever	___ Tonsillitis	___ Sinusitis
___ Allergies	___ To what? _____	
___ Other: _____		

Do you have any eating or swallowing difficulties: If yes, please explain: _____

List any medications you are taking: _____

List any major surgeries, operations, or hospitalizations and dates they occurred:

List any major accidents and when they occurred: _____

Please provide any additional information that may be helpful in the evaluation or treatment process: _____

What are your goals from this evaluation? _____

Consent For Release of Information

I, _____ authorize Speech & Learning Connections, LLC to release/obtain

Print parent/guardian name

Information regarding:

Child/client name: _____

Date of birth: _____

City: _____

County: _____

To/from the following institution(s):

Name: _____

Address: _____

Name: _____

Address: _____

Specific Information to be discussed in written and/or verbal communication:

- | | | |
|--|---------|--------|
| 1. OT/PT Evaluations/Progress Reports/Treatment Plans | Release | Obtain |
| 2. SLP Evaluations/Progress Reports/Treatment Plans | Release | Obtain |
| 3. Feeding Evaluations/Progress Reports/Treatment Plans | Release | Obtain |
| 4. Medical Reports/Progress Notes/Treatment Plans | Release | Obtain |
| 5. IFSP/IEP/RCP | Release | Obtain |
| 6. Vision Reports/Progress Notes/Treatment Plans | Release | Obtain |
| 7. Audiological Evaluations/Progress Notes/Treatment Plans | Release | Obtain |
| 8. Financial Status | Release | Obtain |
| 9. Other _____ | Release | Obtain |

The information obtained/released as a result of this form will be used to provide accurate and comprehensive communication among the service provider team.

This consent for disclosure is valid for one (1) year from the date of signature.

I hereby declare that I understand that I have the right to inspect and receive copy of the information disclosed as a result of this form. I understand that I may withdraw consent at any time by written request. I understand that my refusal to consent to disclosure will not result in any other consequence but information will not be disclosed.

Signature of Parent/Guardian

Date

Witness

Date

Send Information to: Basha Ontiveros
Speech & Learning Connections
2412 E. Washington St. Unit 4B
Bloomington, IL 61704
Phone: (309)663-4172

NOTICE TO RECEIVING AGENCY/PERSON: Under the provisions of the Illinois Mental Health and Developmental Disability Confidentiality Act, you may not re-disclose any information covered by that Act unless the person who consented to this disclosure specifically consents to such re-disclosure.



Informed Consent for Therapeutic Services

I, _____, authorize Speech & Learning Connections to enroll,
Print name of parent/guardian

_____ in the following services:
Print name of client/child

- Speech-Language Therapy
- Feeding Therapy
- Auditory Processing Therapy
- Hearing Screening (if not already specified by therapist)
- Other (specify) _____

By consenting to these services I declare that I understand, and agree with the following:

1. Orientation regarding services has been explained to me in language that I can understand.
2. My consent to services at Speech & Learning Connections is voluntary and can be withdrawn at any time.
3. Written reports/documentation regarding the client/child will not be released except to those individuals whom have been named in a written, signed release form to accept such correspondence.
4. Clients of Speech & Learning Connections may be observed by others interested in similar services at Speech & Learning Connections, and/or students of occupational therapy, speech-language therapy, and psychology and behavioral studies if deemed appropriate by the treating therapist.
5. The client/child's file will be maintained within Speech & Learning Connections for seven (7) years after discharge.

I have read the above information and fully understand the services in which I hereby consent. I release the agency and their trustees, officers, agents, and employees from any liability to the client any personal injury or property damage suffered by the client as a result of participation in these services. I assume all responsibility and agree to indemnify the agency and hold the agency harmless from and against any and all liability or costs associated with or arising from the client's participation in these services. In case of accident or sickness, I consent to emergency medical care provided by ambulance or hospital personnel.

Parent/Guardian Signature

Date

Witness

Date



General Information and Policies

Speech & Learning Connections offers a complete range of services including speech therapy, language therapy, applied behavior analysis (ABA), reading therapy, dyslexia testing and tutoring, central auditory processing screening, auditory training and more. We maintain information on our website. For this information and more, please visit our website at www.speechandlearningconnections.com

Financial Policies

Our financial policies have been written to clearly explain your responsibility for the services provided to you. If you need further information about any of these policies, please ask to speak with our Office Manager.

Health Insurance: Health care insurance may or may not cover services. We will happily bill insurance for you (***for speech-language therapy only - any classes or tutoring cannot be billed to insurance***) however, payment is ultimately your responsibility. If you have health insurance, please bring your plan identification card with you to your first visit. You are responsible for the difference between what your insurance pays and the total charges for your care, less any discounts if we are contracted providers with your plan. There is no guarantee of coverage. If we are not a participating provider for your plan, all fees are payable at the time which services are rendered and reimbursement will be forwarded to you.

No Insurance: If you do not have health insurance, have not met your deductible or another party has accepted financial responsibility for your care, you must pay for services at the time of your visit. We require payment for the initial consultation fee when you check in that will cover the approximate cost of services, tests and supplies. The **entire** balance is due on the first day of each month prior to all subsequent services rendered. Your child's scheduled session is a reserved spot and must be paid for as such. If payments are not received by the seventh day of each month, a \$25 late fee per month will be assessed until the account is paid in full, unless otherwise agreed upon by this office.

Our time is valuable! Your sessions are contracted and reserved on a monthly basis. We are only able to offer one make-up session per month, provided 24 hours notice is given for any cancellation. There are no make-ups allowed for no-shows! Although we will not bill your insurance for missed appointments, you will be responsible for the full amount for your scheduled session. One week per every six months will be allowed for vacation credit provided we are notified 2 weeks in advance. Please note, tutors and therapists will do their best to reschedule a missed appointment, however there are limited times available for make-up sessions and we can only change your child's time if an open slot is available. In addition, make-up sessions may need to be scheduled with a different therapist or tutor than your child regularly works with. Each semester, you will have an opportunity to request a new schedule that will work for your family.

Collection Agencies: If our monthly statements are ignored, a final statement warning that your account will be placed with a collection agency will be mailed to you. If no payment is received within two weeks of the final notice, the account will be sent to a collection agency, where substantial collection costs of 40% will be added to the account balance. In the event that litigation is warranted, all associated legal fees will be your responsibility as well.

Payment Methods: We accept payment by cash, check, VISA, Mastercard, and Discover. Credit card payments can be taken over the phone. ***We require a credit card or debit card to be on file for all clients. This information will be kept secure and will only be used in the event that an account becomes more than 30 days past due.*** We are happy to set-up monthly automatic deductions by credit card if appropriate arrangements are made. If you choose to not provide credit card information, all fees are payable at the time services are rendered and insurance benefits will be forfeited.

Returned Checks: If your check is not honored by your bank because of insufficient funds, your account will be assessed a penalty fee not to exceed the amount allowed by law.

Home Visits: We do, in special circumstances, offer therapy in schools and in homes. 15 minute drive time is factored into the allotted time therapy session. For example, a 45 minute session will be billed at 1 hour. If we are billing insurance, you are responsible for the 15 minute drive time charge, as insurance will not cover this.



Privacy Practices

Speech & Learning Connections has been providing specialty services to residents of central Illinois since 2002. We appreciate the trust that you and hundreds of other clients have placed in us, and one of the ways that we will protect that trust is by respecting the privacy of all our clients, even if our formal therapist-patient relationship ends.

We are required by federal and state law to maintain the privacy of your health information. Federal and state laws allow us to use your health information for treatment, payment, and for other limited uses. We cannot use or disclose your health information for any reason not allowed by law unless you give us written permission. The law does not allow us to speak to a member of your family, another relative, or a close friend who may be involved in your care unless you request in writing that we not do so.

You have the right to make an appointment to look at or get copies of your health information from us, with limited exceptions. You must complete a form available from us to receive copies or have access to your information. You also have the right to receive a list of instances in which we or our business associates disclosed your health information, and you have the right to request that we place additional restrictions on our use or disclosure of your health information, but we are not required to agree to communicate with you about your health information by alternative means or to alternative locations.

If you believe your privacy rights have been violated, you may ask to speak with our Privacy Officer, or you may submit a written complaint to the US Department of Health and Human Services.

Speech & Learning Connections diligently maintains physical, electronic, and procedural safeguards that comply with applicable federal standards to guard your private personal information and to assist us in preventing unauthorized access to that information.

Payment Agreement for Speech & Learning Connections

I understand and agree to the payment and attendance policies listed above. I agree that payment is due prior to the time of service unless otherwise arranged by the office manager.

Client/Parent Name(s):

Date

I hereby authorize Speech and Learning Connections to charge my credit card for any balance in the instance that my account becomes 30 days past due.

Credit /Debit Card Type (circle one) Visa Mastercard Discover Exp. Date ___ / ___ Security Code ___ ___ ___

Credit /Debit Card Number _____

Signature for authorization _____ Date ___ / ___ / ___