



Therapy Group of Tucson, PLLC

2260 N. Rosemont Drive, Ste. 100

Tucson AZ 85712

Phone: (520) 232-2021

Fax: (520) 232-2553

DEMOGRAPHICS

Name:	Age:	Sex: <input type="checkbox"/> male <input type="checkbox"/> female
Social Security #: - -	Date of Birth:	
Street Address:		
City:	State:	Zip Code:
Marital Status : <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Domestic Partner		
Home Phone:	Cell Phone:	
Emergency Contact Name:	Telephone Number:	

Employer Name:	Occupation:
Employer Address:	
City:	State: Zip Code:
Business Phone: ()	
Are you currently working?	If not, last date worked:

Referred By:	Phone: ()
Address:	
City:	State: Zip Code:

PRIMARY INSURANCE INFORMATION

NO INSURANCE (SELF PAY → SEE OUT OF NETWORK/FINANCIAL PRIVATE PAY SECTION FORM)

Insurance Carrier:		
Address:		
City:	State:	Zip Code:
Policy/ Claim #:	Group/ WCB#:	
Adjuster:	Tel:	Fax:
Relationship to insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Other _____		
Insured's Name (if applicable):		
SS No.	DOB:	

SECONDARY INSURANCE INFORMATION

Insurance Carrier:		
Address:		
City:	State:	Zip Code:
Policy/ Claim #:	Group/ WCB#:	
Adjuster:	Tel:	Fax:
Relationship to insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Other _____		
Insured's Name (if applicable):		
SS No.	DOB:	



Important Company Policies for a Successful Relationship

We strive to provide you the best personalized care available. To make this possible we adhere to a set of very important guidelines. Please read them carefully, initial all the boxes, and indicate your agreement by signing/dating on the bottom of this form.

Initial
All
Boxes

Late Policy

Regardless of your arrival time, your appointment time will not change. We do not allow appointment overlap because this compromises the care of another patient.

48-Hour Advance Notice Fee

If you wish to change or cancel an appointment we require a minimum **48-hour advance notice**. Anything less will result in a **\$20 fee** charged to your account. This fee is waived only if the appointment is rescheduled within the same week or a valid Doctor's note is provided.

Copays are due upon arrival

Copays/deductibles/coinsurances are due at time of service. No exceptions. Be advised that you may be balance billed for services not covered by insurance. Non covered services are billed at 45.00 (30 minute appointment) and 60.00 (60 minute appointments).

No-shows are bad

If you fail to show for an appointment without notice all future appointments will be removed and a \$45.00 fee assessed to your account. You may re-schedule appointments again on a "first come, first serve basis."

Do not leave the premises while your child attends therapy

You are not allowed to drop your child off for therapy services and leave the premises for any reason. If there is an emergency and the parent is not present, we will call 911.

Financial Hardship

If you are experiencing financial difficulties and are unable to afford the cost of our services, please speak to us. We have financial options that may be helpful for you. If you qualify for financial assistance according to the Federal guidelines, we may be able to assist you by waiving or discounting your (patient responsibility) portions of the bill.

Insurance Billing and Payment

As a courtesy to you, Therapy Group of Tucson, PLLC will bill your therapy services to your insurance company. Be advised that a prior authorization is not a guarantee of payment. If your charges are applied to deductible, you will be billed that amount. You may be balance-billed the difference between your copay and the cost of the session. **Non covered services are billed at 45.00 (30 minute appointment) and 60.00 (60 minute appointments).**

We look forward to building a successful relationship with that lasts a lifetime!

Parent/Guardian Signature _____

Date: _____

THE THERAPY GROUP OF TUCSON, PLLC
CHILD SPEECH/LANGUAGE PATHOLOGY CASE HISTORY FORM

Please return completed form to:
The Therapy Group of Tucson, PLLC
2260 N Rosemont
Suite 100
Tucson, AZ 85712
Phone: 520-232-2021
Fax: 520-232-2553

IDENTIFYING INFORMATION

Child's Legal Name: _____ Nickname: _____
Date of Birth: _____ Age: _____ Date History Form Completed: _____
Parents'/Legal Guardians' Name(s): _____
Address: _____
Street City/State _____
Zip Code _____
Mailing Address (if different): _____
Person Completing This Form: _____
Name _____
Relationship _____
Mother's Employer: _____ Job Title: _____
Mother's Daytime Phone #: _____ Evening Phone #: _____
Father's Employer: _____ Job Title: _____
Father's Daytime Phone #: _____ Evening Phone #: _____
Child's Soc. Sec. #: _____
Do you have Medicaid? Yes _____ No _____
If yes, please provide your policy/card #: _____ (8 digits)
Name of family doctor or referring physician: _____
Telephone # of family doctor/ referring physician: _____
Name of Insured Individual: _____
Name of Person Responsible for Payment: _____
Address/Phone (if different from above): _____

REFERRAL INFORMATION

Who referred the child to this clinic?
Pediatrician
Relative
Self/Parent
Teacher
Friend
Other _____
Would you like the referring individual to receive a copy of the report? Yes No
Address: _____
Street: _____
City/State Zip Code: _____
Are there others who should receive a copy of the report? Yes No If yes, who?
Name: _____
Address: _____
Street: _____
City/State Zip Code: _____

What is the reason for referral (check all that apply)?

Diagnosis

School Placement

Treatment

Other _____

PRESENT COMMUNICATION STATUS

Please describe your child's speech: _____

Have diagnostic or therapeutic services related to the speech problem previously been received? Yes No

If yes, by whom and when? _____

Results of previous diagnosis or therapy: _____

When did the problem first begin? _____

Has the problem: remained the same gradually worsened worsened quickly?

EDUCATIONAL HISTORY

Name of Current Preschool/School: _____

Grade: _____ Primary Placement:

Regular Ed. Classroom

Self-Contained Classroom (Full Day)

Special Education (Part-Day)

Other _____

Teacher's Name: _____

Describe the child's progress in school: _____

In your opinion, does the child's speech/language problem have an effect on his/her school performance or school placement? Yes No If yes, please explain:

Does the child receive speech-language therapy at school? Yes No

If yes, please indicate the following:

• Name of Clinician: _____

• Length and frequency of sessions: _____

• Primary focus of therapy: _____

FAMILY HISTORY

Mother's Name: _____ Age: _____ Highest Degree/Grade: _____

Father's Name: _____ Age: _____ Highest Degree/Grade: _____

Siblings:

Name: _____ Age: _____ Highest Degree/Grade: _____

Name: _____ Age: _____ Highest Degree/Grade: _____

Name: _____ Age: _____ Highest Degree/Grade: _____

Name: _____ Age: _____ Highest Degree/Grade: _____

Others in the Home: _____

Name _____

Relationship _____

Name _____

Relationship _____

PREGNANCY AND BIRTH HISTORY

Did the birth mother have any illnesses or accidents during the pregnancy? Yes No

Did the birth mother receive/take any prescribed medications while pregnant? Yes No

If yes, what medications and for how long? _____

Where the medications used during the: __first trimester __second trimester __third trimester?

Did the birth mother drink alcohol or use any illegal drugs while pregnant? Yes No

Were there any complications during the pregnancy? __Yes__ No

Were there any complications during the labor and/or delivery?

Yes No

Was the baby's birth: __premature __term __late?

Did the baby have difficulty with any of the following in the first 48 hours following birth?

breathing

crying

sleeping

sucking

responding to noise

other

Comments on any of the above: _____

How long did the baby remain in the hospital following birth? _____

DEVELOPMENTAL HISTORY

I have never been concerned about my child's developmental patterns. Yes No

I am concerned about my child's development because _____

Please indicate the approximate ages at which each of the following occurred for the first time:

_____ Cooing

_____ Ask Questions

_____ Feed Self/Hands

_____ Babbling

_____ Sit Unassisted

_____ Feed Self/Utensil

_____ Single Words

_____ Stand Unassisted

_____ Toiled Trained

_____ Combine Words

_____ Walk Unassisted

_____ Dress Self

Is English the child's native language? Yes No

If not, what is the child's native language? _____

How many languages are spoken in the home? _____ Which languages? _____

MEDICAL HISTORY

General Health:

Excellent

Good

Fair

Poor

Please indicate any ongoing medical conditions: _____

Please indicate any regular medications: _____

Has the child ever been seen by any of the following specialists? Check all that apply:

- ENT Physician
- Psychologist
- Nutritionist
- Neurologist
- Behavior Specialist
- Orthodontist
- Psychiatrist
- Physical Therapist
- Physiatrist
- Occupational Therapist
- Other: _____

Please list previous surgeries/illnesses/injuries:

PROBLEM: _____
DATES: _____ COMMENTS: _____

Please check all that apply and provide clarifying information under "Comment":

- Allergies
- Recurrent colds/flu/sore throat
- Dizziness
- Dental problems
- Frequent laryngitis/ hoarseness
- Epilepsy/seizure disorder
- Reading and/or spelling problems
- Other academic problems
- Attention Deficit Disorder (ADD)
- ADD with Hyperactivity (ADHD)
- Vision problems
- High fevers
- Kidney problems
- Swallowing/digestive disorders
- Respiratory difficulties
- Heart/circulatory problems
- Neurological disorders
- Cancer
- Endocrine/metabolic disorders (thyroid problems, diabetes)
- Viruses (HIV, Herpes)
- Connective Tissue Disorders (Lupus, Rheumatoid Arthritis)
- Frequent and/or intense headaches
- Measles
- Mumps
- Chicken Pox
- Meningitis
- Unusual fatigue/stress
- Mental illness
- Congenital disorders (list please)

Please list names/approximate dates/reason for specialists:

Name: _____ Date: _____
Reason for Involvement: _____
Name: _____ Date: _____
Reason for Involvement: _____

AUDIOLOGICAL HISTORY

My child had 3+ ear infections between birth and 12 months of age. YES NO

My child has had at least one ear infection which lasted more than 3 months. YES NO

My child has been evaluated by an audiologist who determined that his/her hearing is within normal limits. YES NO Date of visit: _____

My child has failed a hearing screening in school. YES NO Date of screening: _____

My child has passed a hearing screening in school. YES NO Date of screening: _____

I suspect my child has a hearing problem. YES NO

My child prefers one ear over the other. YES NO If yes, which ear? R L

My child has had tubes in his/her ears. YES NO If yes, when? _____

My child wears hearing aids. YES NO If yes, what type, and for how long?

Comments: _____

SPEECH AND LANGUAGE HISTORY

My child follows directions well. YES NO

My child gives directions well. YES NO

My child asks for help when needed. YES NO

My child expresses himself/herself in a coherent manner that is understood by others. YES NO

My child likes to have stories read to him/her. YES NO

How long does he/she attend to the story? _____

My child plays with age-appropriate toys appropriately. YES NO

My child has failed a speech screening in school. YES NO Date of screening: _____

My child has passed a speech screening in school. YES NO Date of screening: _____

My child communicates primarily through whining/crying. YES NO

My child communicates primarily through gesturing/pointing. YES NO

My child tries to communicate through verbalizing, but cannot be understood. YES NO

My child primarily uses one-word utterances to communicate. YES NO

My child primarily uses two-word phrases to communicate. YES NO

My child primarily combines 3+ words to communicate. YES NO

My child uses proper sentence structure for most of his/her utterances. YES NO

My child's communication efforts are easily understood by familiar persons. YES NO

My child's communication efforts are easily understood by unfamiliar persons. YES NO

My child frequently drools. YES NO

My child has difficulty chewing his/her food. YES NO

I am concerned about my child's speech (how well what he/she says can be understood). YES NO

I am concerned about my child's language development (the content of what he/she says; how well he/she understands what others say). YES NO

Overall, I would rate my child's speech intelligibility as:

___Excellent___ Good ___Fair___ Poor ___ Completely unintelligible

Comments: _____

Today's Date: _____

NOTICE OF PRIVACY POLICIES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Therapy Group of Tucson, PLLC is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other health care professionals within our practice for the purpose of treatment, payment, or healthcare operations.

Payment

We may disclose your health information to your insurance provider and DDD for the purpose of payment or health care operations.

Public Health

As required by law, we may disclose your health information to the public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety

We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Secure Areas

Our office and all medical records are a secured area with no public access. All staff are trained in regards to medical records security and HIPPA compliance.

Change of Ownership

In the event that Therapy Group of Tucson, PLLC is sold or merged with another organization, your health information/record will become property of the new entity.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Therapy Group of Tucson, PLLC is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon request.
- You have the right to inspect and copy your health information.
- You have the right to request that Therapy Group of Tucson, PLLC amend your protected health information. Please be advised, however, that Therapy Group of Tucson, PLLC is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Therapy Group of Tucson, PLLC.
- You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Therapy Group of Tucson, PLLC reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Therapy Group of Tucson, PLLC is required by law to comply with this Notice

Therapy Group of Tucson, PLLC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about your privacy rights, please contact Therapy Group of Tucson, PLLC by calling this office 520-232-2021. If John Kyle Meades is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights or how Therapy Group of Tucson, PLLC has handled your health information should be directed to John Kyle Meades by calling this office 520-232-2021. If John Kyle Meades is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Therapy Group of Tucson, PLLC with authorization and consent to use and disclose my protected health care information for purposes of treatment, payment, and health care operations as described in the Privacy Notice.

Signature provided on the Consent, Release, and Assignment page.

Consent, Release, & Assignment

I certify the above is a complete and accurate account of all medical insurance policies.

** I give permission to Therapy Group of Tucson, PLLC and the contracted therapists to contact my physician to discuss screening results and obtain physician's orders for therapy evaluation and treatment.

Physician: _____

Clinic Phone Number: _____

** _____ I grant permission for a photo/image that includes my child, without any other personal identifiers, to be published on the Therapy Group of Tucson, PLLC website/Facebook.

** _____ I DO NOT grant permission for a photo /image that includes my child, without any other personal identifiers, to be published on the Therapy Group of Tucson, PLLC website/Facebook.

Child's name (print) _____

I consent to Therapy Group of Tucson, PLLC providing an evaluation and/or ongoing therapy services.

I understand that evaluation results and therapy recommendations are available to me upon request. Therapies being provided are: SPEECH-LANGUAGE EVALUATION and/or SPEECH-LANGUAGE THERAPY

I authorize the release of information for exchange between Therapy Group of Tucson, PLLC, Division of Developmental Disabilities and physician's office as they apply to the provision of therapies.

I have received a copy of the Notice of Privacy Practices for Protected Health Information.

I authorize the release of all information in order to process claims for services. I authorize direct payment to Therapy Group of Tucson, PLLC. Payments received from the HMO or insurance company to the consumer will be forwarded to Therapy Group of Tucson, PLLC.

Patient/Guardian printed Name: _____

Patient/Guardian Signature: _____

Today's Date: _____