CHILD HISTORY FORM

Child's Name _____ D.O.B. _____ Age ___
Address _____
City _____ State _____ Zip _____

School _____ Grade Level _____ Doctor _____

Child's Soc. Sec. Number _____ Referred by _____

Insurance _____ ID # _____

Child resides with _____ Relationship to child _____
(Name)
Information provided by _____ Relationship to child _____
(Name)

Parent/Guardian information – Please fill out information for the parent(s) or guardian(s) that the child currently resides with. Please circle the appropriate title for each parent/guardian.

Mother/Guardian _____ SS# _____ D.O.B. _____
Home # _____ Work # _____ Cell. # _____
Address _____
City _____ State _____ Zip _____
Place of Employment _____
Emergency Contact _____Phone_____

Father/Guardian _____ SS# _____ D.O.B. _____
Home # _____ Work # _____ Cell. # _____
Address _____
City _____ State _____ Zip _____
Place of Employment _____
Emergency Contact _____Phone_____

I authorize Mary Pellegrino and Associates to leave messages at the phone numbers indicated above.

_____ _____
Responsible Party Signature Date

Please describe the difficulties your child is having with his/her speech and/or language.

Is your child having any difficulties in school? If so, please describe. _____

Is your child having any difficulties with reading, writing or following directions? _____

Other children in family:

Name	Age	Sex	School	Grade Level	Speech/Lang. Difficulties

HEALTH OF MOTHER DURING PREGNANCY

1. Any unusual illness (measles, RH Blood Factor, etc.)? Yes No
2. Any history of miscarriages? Yes No
3. Pregnancy- _____ months
4. Birth weight _____lbs _____oz.

CIRCLE ANY OF THE FOLLOWING WHICH MAY APPLY:

Breech birth	Instruments Used	Cesarean Section
Trouble Breathing	Dry Birth	Unusual Color at Birth
Unusual Scars/Bruises	Incubator Used	

HEALTH AND DEVELOPMENT OF CHILD

Current Medications	Purpose	Dose/Schedule

ASSISTIVE DEVICES:

___ Wheelchair	___ Glasses/Contact lenses
___ Hearing Aid	___ Positioning Devices
___ Dentures	___ Communication Device
___ Walker	___ Other (lip read, etc.)

Allergies: _____
(Please list allergies to medications, foods and environmental substances.

Immunizations current? Yes No

Diet:	Manner of eating:	Diet Consistency:
___ Regular	___ Feeding self	___ Regular
___ Low fat	___ Needs assistance	___ Chopped
___ Low sodium	___ Uses hands	___ Puree
___ Other _____	___ Uses utensils	___ Thickened liquids

Activities enjoyed? List any activities that the child enjoys, including favorite music and television shows. _____

PLEASE EXPLAIN ANY QUESTIONS ANSWERED, "YES" BELOW.

1. Age he/she sat alone? _____months
2. Age he/she walked alone? _____months
3. Toilet training began at age _____months.
4. Child was completely toilet trained by _____ months.
5. Child's development has been:

	BELOW AVERAGE	**AVERAGE**	**ABOVE AVERAGE**
6. Coordination:	Good	Clumsy	
7. Feeding difficulties:	Yes	No	
8. Difficulty swallowing/choking:		Yes	No
9. Eye problems:	Yes	No	
10. Any serious illness?	Yes	No	

11. History of high fevers? Yes No

12. History of seizures or convulsions? Yes No

13. Any serious accidents? Yes No

14. Any surgical operations? Yes No

15. Have tonsils or adenoids been removed? Yes No

16. Does child have frequent colds, sore throats or earaches? Yes No

17. Has child ever lost consciousness? Yes No

18. If there are any other medical or behavioral problems not listed above, please describe briefly here: _____

---

19. Is the child: ___ right handed ___ left handed ___ uses both

SPEECH AND LANGUAGE HISTORY

1. Was the child responsive as an infant (smile/cry, babble, coo, etc. appropriately)?

2. At what age did the child first begin:

    a. Using first words? ___
    b. Using phrases? ___
    c. Using sentences? ___

3. At what time were you first concerned about your child's speech/hearing problem?

4. Does child seem aware of his/her speech/hearing problem?

5. Can child be understood by:

    a. Parents? Yes No
    b. Relatives? Yes No
    c. Strangers? Yes No
    d. Children? Yes No

6. What percentage of your child's speech do you understand?

7. Has the child ever been seen for a speech or hearing evaluation, examination or therapy by anyone other than your doctor?

8. My child communicates now by:

___ Crying/whining

___ Hand gestures (pointing at food)

___ Babbling (da-da-da)

___ Puts words together

___ Uses single words

9. Are you concerned about your child's hearing? Yes No

BEHAVIOR

Circle any of the following that describes the behavior of your child:

Nervous/sensitive	Short attention span	Shy
Temper tantrums	Cries easily	Withdrawn
Wets the bed	Easily managed	Slow learner
Thumb sucker	Behavior problem	Demands attention
Restless sleeper	Unusual fears	Plays well with playmates
Overly active	Overly talkative	Has no playmates
Prefers to play alone		

Will the child separate easily from his/her parents for the evaluation? Yes No

OFFICE POLICIES AND PROCEDURES

Cancellations

- If for any reason you must cancel your appointment, a 24-hour notice is requested. If any patient misses two appointments without prior notice, that patient will be removed from our schedule. There is a $30.00 fee for appointments missed without prior notice. Patients who are sick will not be seen for therapy sessions. It is at the discretion of the therapist to determine if a child is too sick to receive services.

Billing Policies

- Our office will file insurance as a courtesy for patients. Any balance left unpaid after 60 days will automatically become the responsibility of the patient. All patient balances over 30 days are subject to an 18% finance charge. Co-payment and deductible amounts must be paid at the time services are rendered. There is a travel/gas charge of $50.00/month per weekly half hour session for any child that is seen at his/her school/daycare. This expense is not covered by insurance companies and is due at the beginning of each month. Speech therapy is considered a medical expense and may be a tax deduction.

Private Pay

- Our private pay fee scale is available to patients who do not have insurance coverage for speech therapy or for patients who have exhausted their insurance benefits. The fees for services are as follows:

  Initial Evaluation- $350.00
  1x per week- $300.00/month (4 or 5 sessions)
  2x per week- $500.00/month (8 or 9 sessions)
  3x per week- $650.00/month (12 or 13 sessions)

- If you wish to pay per session, the per session fee is $80/per ½ hour session ($160.00/per hour)

Private pay amounts are due at the time of the **first session of each month.** Appointments that are cancelled with 24 hours notice must be rescheduled within the current month. Appointments that are missed without prior notice **will not be rescheduled.**

I have read and understand the office policies and procedures.

_____ _____
Responsible Party Signature Date

PATIENT RIGHTS AND MEDICAL RECORDS

Patient Rights

1. The patient has the right to expect quality services and treatment in accordance with professional standards of practice.
2. The patient has the right to refuse treatment.
3. The patient has the right to be treated with respect and dignity.
4. The patient has the right to be informed of any treatment that is being provided.
5. The patient has the right to receive education in reference to services being provided.
6. The patient has the right to confidentiality of all patient information.
7. The patient has the right to privacy during all phases of treatment.
8. The patient has a right to remain free of injury during all phases of treatment.
9. The patient has a right to disagree with and/or question services being provided in a respectful manner.
10. The patient has a right to make informed decisions before receiving treatment.
11. The patient has a right to file a grievance utilizing the grievance procedure.
12. The patient has the right to have all patient rights protected by the professionals.

I have read and understand the patient rights

_____ _____

Responsible Party Signature Date

Medical Records

1. All patient records will be kept confidential.
2. All medical records will be made available to insurance companies as necessary for treatment and payment purposes.
3. Records will be released to a third party only by written request of the patient.
4. All patients have the right to request records at any time.
5. Changes can be made to medical records by request of the patient to correct errors or incorrect information.

I have read and understand the medical records policy.

_____ _____

Responsible Party Signature Date

GRIEVANCE PROCEDURE

Mary Pellegrino and Associates makes every attempt to satisfy all patients with services provided. If, however, you have any complaints, we ask that you abide by the following procedures:

Your therapist will sit down with you, your guardian, or anyone else you choose and attempt to resolve the problem. Sometimes problems can be worked out simply by sitting down and discussing them. If this matter cannot be resolved to your satisfaction, Please present your complaint in writing. Our office will provide you with a written response to you grievance and both correspondences will be kept in our grievance log.

Your grievance must contain the following information to be maintained in our log:

1. Name of the person making the complaint.
2. The complainant's relationship to the person receiving the services.
3. Date of the complaint.
4. A clear description of the complaint.

This acknowledges that I understand the grievance procedure.

_____ _____

Responsible Party (print name) Date

_____

Responsible Party Signature

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name_____ Date of Birth_____

I,_____ give my consent for an exchange of information

between:

Mary Pellegrino and Associates
3215 Capital Medical Blvd.
Tallahassee, Fl 32308
ph (850) 878-0609 fax (850) 877-1057

and:

_____
Name of Primary care physician or entity to which records are to be released.

_____
Street Address

_____
City State Zip

_____
Phone Fax

My signature means that:

1. I have read this authorization. I understand and agree to its contents.
2. I have been informed that no other information may be released without my written consent.
3. I have been informed that I may revoke this authorization by written statement at any time.

Signed:

_____ _____
Client (if not a minor) Witness

_____
Parent / Guardian (if a minor)

Parents with children under the age of 3 years

We are providers for Children's Home Society which provides free Speech-Language services. These services are available to you if your child qualifies.

If you are interested we will contact Children's Home society for your child. Please indicate below if you are or are not interested in these services.

____ Yes, I would like Mary Pellegrino & Associates to refer my child to Children's Home Society.

____ No, I would not like Mary Pellegrino & Associates to refer my child to Children's Home Society.

_____ _____

Signature Date

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, plus how you can get access to this information. Please review it carefully.

1. All patient records will be kept confidential.
2. Original records will not leave the facility.
3. Records will be released to a third party only by written request of the patient, parent or guardian.
4. All patients have the right to request copies or inspect their records at any time.
5. Requests for changes to medical records can be made at any time.
6. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or healthcare operations. This must be requested in writing.
7. We may use and disclose protected health information (PHI) about you in the following circumstances:
    - To provide treatment to you
    - To obtain payment for services
    - To conduct health care operations
    - Under certain circumstances without your authorization as required by law or in response to a valid subpoena
    - To provide appointment reminders
    - To contact you with information about treatment, services, products or healthcare providers
    - Under certain circumstances if you do not object or agree
8. You have several rights regarding you PHI:
    - The right to see and copy your PHI
    - The right to request amendments to your PHI
    - The right to a listing of non-routine disclosures we have made
    - The right to request restrictions on uses and disclosures of your PHI
    - The right to object to certain uses and disclosures
    - The right to request different ways to communicate with you
9. If you believe your privacy rights have been violated, you may file a complaint with the privacy officer at this facility or with the secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
10. You have the right to request restrictions in how we communicate with you via your home and work. All requests must be made in writing to the privacy officer and must specify how and where you wish to be contacted.

I have read and received a copy of the privacy practices.

_____ _____

Responsible Party Signature Date

CLIENT COPY

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, plus how you can get access to this information. Please review it carefully.

1. All patient records will be kept confidential.
2. Original records will not leave the facility.
3. Records will be released to a third party only by written request of the patient, parent or guardian.
4. All patients have the right to request copies or inspect their records at any time.
5. Requests for changes to medical records can be made at any time.
6. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or healthcare operations. This must be requested in writing.
7. We may use and disclose protected health information (PHI) about you in the following circumstances:
    a. To provide treatment to you
    b. To obtain payment for services
    c. To conduct health care operations
    d. Under certain circumstances without your authorization as required by law or in response to a valid subpoena
    e. To provide appointment reminders
    f. To contact you with information about treatment, services, products or healthcare providers
    g. Under certain circumstances if you do not object or agree
8. You have several rights regarding you PHI:
    a. The right to see and copy your PHI
    b. The right to request amendments to your PHI
    c. The right to a listing of non-routine disclosures we have made
    d. The right to request restrictions on uses and disclosures of your PHI
    e. The right to object to certain uses and disclosures
    f. The right to request different ways to communicate with you
9. If you believe your privacy rights have been violated, you may file a complaint with the privacy officer at this facility or with the secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
10. You have the right to request restrictions in how we communicate with you via your home and work. All requests must be made in writing to the privacy officer and must specify how and where you wish to be contacted.