Across the Board THERAPY GROUP
SPEECH · BEHAVIORAL/ABA · OCCUPATIONAL · PHYSICAL · AUDIOLOGY

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ADMISSION & CONSENT

NAME OF PATIENT:_____
DATE OF BIRTH:_____ AGE:_____

NAME OF PARENT/GUARDIAN:_____
RELATIONSHIP TO PARENT/GUARDIAN:_____
ADDRESS:_____
CITY/STATE/ZIP:_____
HOME PHONE:_____CELL PHONE:_____
EMAIL ADDRESS:_____
DRIVER LICENSE #:_____

EMPLOYMENT INFORMATION
EMPLOYER:_____
PHONE :_____EXT.:_____
ADDRESS OF EMPLOYMENT:_____
CITY/STATE/ZIP:_____

NAME OF PRIMARY INSURANCE:_____

WE ARE SORRY FOR THE INCONVENIENCE, HOWEVER WE DO NOT ACCEPT SECONDARY INSURANCES.

PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD(S) SO A COPY CAN BE MADE.

I HEREBY CONSENT TO **ACROSS THE BOARD THERAPY GROUP, LLC**, TO FURNISH THERAPY SERVICES TO _____ AS PRESCRIBED BY THE PHYSICIAN. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO **ACROSS THE BOARD THERAPY GROUP, LLC**, OF THE INDIVIDUAL OR GROUP INSURANCE BENEFITS SPECIFIED AND OTHERWISE PAYABLE TO ME. I UNDERSTAND I AM FULLY RESPONSIBLE TO **ACROSS THE BOARD THERAPY GROUP, LLC**, FOR ALL CHARGES NOT PAID BY MY INSURANCE PROVIDER. **ACROSS THE BOARD THERAPY GROUP, LLC** IS AUTHORIZED TO RELEASE TO SAID INSURANCE COMPANIES AND TRANSWORLD SYSTEMS INC. ANY/ALL OF THE INFORMATION LISTED ABOVE AND/OR MEDICAL RECORDS.

PATIENT OR PARENT
SIGNATURE:_____DATE:_____

WITNESS:_____DATE:_____

Across the Board THERAPY GROUP

SPEECH BEHAVIORAL/ABA OCCUPATIONAL PHYSICAL AUDIOLOGY

Release Form

I_____, authorize_____to release information to Across the Board Therapy Group, LLC.

Signed:_____

Date:_____

I, _____authorize Across the Board Therapy Group, LLC, to release information to_____.

Signed:_____

Date:_____

I have read and understand the privacy policy at Across the Board Therapy Group, LLC, regarding my protected health information.

Signed:_____

Date:_____

Across the Board THERAPY GROUP

SPEECH BEHAVIORAL/ABA OCCUPATIONAL PHYSICAL AUDIOLOGY

Across the Board Therapy Group, LLC Policies

Attendance:
At Across the Board Therapy Group, scheduled appointments are a bond between our therapists and our patients. This is our opportunity to provide the highest standard of care to each patient. To help us honor our commitment to your care, we ask all families to follow a few simple guidelines:

(1) Arrive for your appointment on time
(2) Provide at least a 24 hour notice for cancelations
(3) Limit number of cancelations
(4) Honor our bond

We realize that emergencies happen and schedules change. However, appointments that are habitually missed, canceled, or changed will result in the one of following actions:

(1) Loss of your regular appointment time
(2) Reduction in the number of weekly appointments
(3) Discharge from this facility as a result of poor attendance

If we feel attendance patterns are habitually not meeting our expectations, we reserve the right to initiate the above procedures at our discretion.

No show appointments will result in a $25 charge. That charge is not covered by insurance and will be to responsibility of the guarantor on the account. Failure to pay the charge will result in discharge from this facility. Cancelations at or during your scheduled therapy session is considered a no show.

Illness:
If your child is sick please do not bring him/her to therapy until they are sufficiently well. Some of our patients maybe medically fragile, therefore, do not bring sick siblings into the clinic either.

Payment:
Unless other arrangements have been made, payment is due at the time of service. Medical records will not be released if there is an outstanding balance.

Facility:
Parents are to remain at the center during their child's services. If it is necessary to leave, the parents must provide a phone number where they can be reached. Typically, pediatric sessions are every 30 minutes, therefore, parents are asked to be present 5 minutes prior to the end of the session to discuss their child's progress and home activities.

Signed:_____ **Date:**_____

Across the Board THERAPY GROUP

SPEECH BEHAVIORAL/ABA OCCUPATIONAL PHYSICAL AUDIOLOGY

Case History Form

Patient's Name:_____

Age:_____**Birthdate:**_____**Sex:**___**Male**___**Female**

Parent(s)/Guardian's Name:_____

Address:_____

Phone:_____**Cell:**_____

Email Address:_____

Primary Physician's Name:_____

Physician's Phone:_____

List any other children in the family:

Name:	**Age:**	**Sex:**	**Speech/Hearing/Developmental Problems:**

Is there a language other than English spoken in the home?____**yes**_____**no**
If yes, please list:_____

Birth History

Age of mother at the time of birth:_____

Length of pregnancy:_____**Birth weight:**_____

Type of delivery:____**vaginal**____**cesarean**

Were there any complications with the birth/pregnancy:____**yes**_____**no**
If yes, please describe:_____
_____

Across the Board THERAPY GROUP

SPEECH BEHAVIORAL/ABA OCCUPATIONAL PHYSICAL AUDIOLOGY

Developmental History

Please tell the approximate age your child achieved the following developmental milestones:

sat alone:_____first word:_____crawled:_____walked:_____toilet trained:_____

feed self:_____grasped crayon/pencil:_____

If your child is writing, what is his/her dominant hand?_____

Does your child:

_____use a bottle_____sippy cup_____drink from an open cup
_____suck his/her thumb
_____use a pacifier
_____dress him/herself
_____use a wheelchair

Has your child had an eye exam?____yes____no
If yes, what were the results:_____

Has your child had his/her hearing tested?____yes____no
If yes, what were the results:_____

Medical History

Has your child had any of the following?

_____adenoidectomy
_____allergies
_____breathing difficulties
_____chicken pox
_____colds
_____ear infections
how many?_____
_____ear tubes
_____encephalitis
_____flu
_____head injury
_____high fevers
_____measles
_____mumps
_____rubella
_____scarlet fever
_____seizures
_____sinusitis
_____sleeping issues
_____tonsillectomy
_____tonsillitis

Has your child ever been hospitalized?_____yes_____no. If yes, please explain:

_____

_____

Please list any medications your child is currently taking:_____

_____

Please list any food or drug allergies:_____

Speech/Language and/or Occupational History

How does your child currently communicate his/her wants and needs:_____
_____

Please explain your concerns with your child's speech/language skills:_____
_____

When did you first notice a problem:_____

Has your child ever received any speech therapy?_____yes_____no
If yes, when, where and for how long:_____
_____

Has your child ever received, or is currently receiving, any other special services (occupational therapy, physical therapy, specialized physician)_____yes_____no
If yes, please list:_____

Does your child have any of the following behavioral issues:

____poor attention
____separation difficulties
____easily frustrated
____restless
____poor eye contact
____easily distracted
____destructive/aggressive

School History

Name of school:_____Grade level:_____

Does your child receive any special services at school?____yes____no
If yes, please list:_____

How is your child doing academically?_____

Additional Comments

Please provide any additional information about your concern you would like us to know:
_____

HIPPAA Notice of Privacy Practices

This notice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health services.

1. Uses and Disclosures of Protected Health Information-

Your protected health information may be used and disclosed by your therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician/therapist's practice, and any other use required by law.

a. Treatment-

We will use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a 3rd party. For example, we would disclose your information as necessary to a home health agency that cares for you or to a physician to whom you have been referred to ensure the physician/therapist has the necessary information to diagnose and treat you.

b. Payment-

Your protected health information will be used,as needed, to obtain payment for your health care services.

c. Healthcare Operations-

We may use or disclose, as-needed, your protected health information in order to support the business activities of your physicians/therapists practice. These activities include, but are not limited to, quality assessment activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your therapist. We may also call your name in the waiting room when your physician/therapist is ready to see you. We may use or disclose your protected health information in the following situations without your authorization: as required by law. Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician/therapist or physician/therapist's clinic has taken an action in reliance on the use of disclosure indicated in the authorization.

YOUR RIGHTS:

You have the right to inspect and copy your protected health information. However, you may not inspect or copy the following records. Psychotherapy notes, information compiled in reasonable anticipation of or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You have the right to request a restriction of your information. You have the right to request confidential communications from us even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to have your physician/therapist amend your protected health information. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

Complaints:

You may complain to us or to the Secretary of Health and Humana Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask us to explain. Signature below confirms acknowledgement of our Privacy Practices:

Signature_____ **Print Name**_____ **Date**_____