CreativeTherapyWorks,LLC

…creating therapy that **WILL** work for YOU!

www.creativetherapyworks.com

Patient Information

Name: _____ Today's Date: _____

Sex: ☐ Male ☐ Female

Date of Birth: _____

Preferred contact method:

☐ Home Phone: _____

☐ Work Phone: _____

☐ Cell Phone: _____

☐ E-mail: _____

Address: _____

City: _____ State: _____ Zip: _____

Parent's Name: _____

Parent's Employer: _____

Primary Care Physician's Name: _____

Primary Care Physician's Address: _____

City: _____ State: _____ Zip: _____

How did you hear about this practice?

☐ Doctor ☐ Self

☐ Friend/Family Member ☐ Other

Insurance Information

Please provide a copy of your insurance card

Primary Insurance: _____

Policy Holder Name: _____

Group Number: _____

Phone Number: _____

Secondary Insurance: _____

Policy Holder Name: _____

Group Number: _____

Phone Number: _____

_____

Name of Person Completing This Form/ Relationship to Patient

CONFIDENTIAL PARENT QUESTIONNAIRE FOR SPEECH/LANGUAGE & HEARING EVALUATION
(All information provided is strictly confidential and will not be provided to any other agency without your written consent.)

Child's Name: _____ Evaluation Date: _____

Child's Age: _____ Date of Birth:_____

Mother's Name: _____ Age: _____ Occupation: _____

Father's Name: _____ Age: _____ Occupation: _____

Referred to Creative Therapy Works, LLC by: _____

I. GENERAL INFORMATION

1. Describe what concerns you have about your child's development: _____

_____

_____

_____

2. When did you first notice this problem? _____

_____

3. List other professionals who have evaluated your child and any diagnosis made (include dates):

_____ _____

_____ _____

_____ _____

4. Has your child received any previous treatment for this specific problem? ____ yes _____no

5. If yes, where/when: _____

_____

_____

6. Is a second language spoken in the home? _____ If so, what language? _____

7. Please list brothers and/or sisters of the child and their ages:

_____

_____

8. Please list any additional people living in your home, their ages, and relationship to child:

_____

_____

9. What specific questions do you have relating to this evaluation and your child's speech/ language?

_____

_____

_____

II. DEVELOPMENTAL HISTORY

A. Prenatal:

1. How was the health of the mother during this pregnancy? _____

_____

2. Any accidents or illnesses? _____ If so, please explain briefly: _____

_____

3. Has the mother had any problems with other pregnancies before or after this? _____ If so, please explain: _____

4. Please check any conditions that applied to the mother during this pregnancy:

____Nervous & apprehensive ____RH negative ____Unusually happy ____Moody ____Headaches

____High blood pressure ____Virus infections ____German Measles ____Toxic condition

____ Bed rest or hospitalization ____ Use of Pitocin or Breathine

Other: _____

5. If mother had German Measles (Rubella) or was exposed to it, please give month of gestation in which it occurred(first, second, third, etc.): _____

6. If virus infections, give type and month occurred: _____

7. Did the mother take any medication or drugs during this pregnancy? _____ If so, what? _____

_____

B. Peri-natal:

1. Weight of child at birth: _____ pounds, _____ounces

2. Duration of pregnancy: _____months

3. Was there false labor? _____

4. How long was labor? _____

5. How long before delivery did water break? _____

6. Were instruments used? _____ If so, what? _____

7. What kind of anesthesia was given to the mother? _____

8. Was the delivery: ___Spontaneous ____Induced ____Cesarean Section ___ Breech

9. Was there anything unusual in the baby's condition at birth or soon after, such as:

____ Injury ___ Paralysis ____ Cord wrapped around neck _____Bruises

____ Coloring (blue or yellow) ____ Other (explain): _____

10. Was the baby given blood transfusions or exchanges at birth? _____

11. Was the baby given oxygen? _____

12. Were there any problems after birth? _____ Such as: ____ Feeding problems _____ Seizures _____

Other Illness: (explain) _____

_____

III. FEEDING HISTORY

Circle "yes" or "no" to indicate if your child has/ had any difficulty with the following:

Yes	No	Problems with sucking/ nursing	Transition from bottle to baby food	Yes	No
Yes	No	Choking or gagging	History of aspiration	Yes	No
Yes	No	Reflux	Difficulty chewing or swallowing	Yes	No
Yes	No	Does your child feed self with a spoon?	Regurgitation of liquids or solids through nose	Yes	No
Yes	No	Does your child drool?	Tube feeding (NG, OG, or g-tube)	Yes	No
Yes	No	Does your child avoid food textures? If yes, please explain: _____ _____	Is your child a picky eater. If "yes" what food does he/she prefer? _____ _____	Yes	No

IV. PLAY BEHAVIORS

Does your child enjoy/ do the following:

Yes	No	Look at books	Putting toys in mouth	Yes	No
Yes	No	Rough and tumble play	Use objects appropriately	Yes	No
Yes	No	Role play	Playing with others	Yes	No
Yes	No	Make- believe play	Playing alone	Yes	No
Yes	No	Games with rules	Playing with repetitive toys	Yes	No
Yes	No	Acting out familiar routines			

V. MOTOR DEVELOPMENT

1. At what age did the child do the following?

_____ Head support
_____ Sit alone
_____ Crawl
_____ Walk alone
_____ Drink from a cup
_____ Pull off his socks
_____ Eat with spoon
_____ Ask to go to the toilet

2. Does the child:

____ Prefer the right or left hand?
____ Fall, lose balance easily
____ Grasp objects readily?
____ Have difficulty chewing and/or swallowing
____ Have a peculiar walk?
____ Seem awkward and uncoordinated?

VI. HEALTH HISTORY

1. Check any illnesses the child has had. Specify information, such as age, degree of temperature, medical treatment received:

☐	**Measles**	☐	**Chicken Pox**	☐	**Frequent Colds**
☐	**Meningitis**	☐	**Convulsions/ Seizures**	☐	**Pneumonia**
☐	**Whooping Cough**	☐	**Mumps**	☐	**Bronchitis**
☐	**Poliomyelitis**	☐	**Falls/ blows to the head**	☐	**Asthma**
☐	**Scarlet Fever**	☐	**Tonsillitis**	☐	
☐	**Influenza**	☐	**Frequent Ear Infections**	☐	
☐	**Epilepsy**	☐	**Allergies**	☐	

2. If you child has had more than one ear infection, how old was the child when the ear infections occurred?

_____

3. How were the ear infections treated (antibiotics, tube, etc.)? _____

Check any surgery your child has had. Specify date of surgery, where, duration of hospitalization, and attending physician:

	Date / Duration of Hospitalization	Attending Physician
☐ Tonsillectomy		
☐ Adenoidectomy		
☐ Ear Surgery		
☐ Oral Surgery		
☐ Other:_____		
☐ Other: _____		
☐ Other: _____		

3. Is the child presently on medication? _____ If so, specify by name and reason prescribed:

_____

4. Are there any members of the family who have hearing or speech difficulties? _____ If so, please specify who and what the difficulty was: _____

5. Does any member of the family have similar problems that the child has? _____

6. Is child allergic to food, drink, insect bites, etc: _____ Explain: _____

VII. EMOTIONAL ADJUSTMENT **(please circle yes or no if the statement is something that currently pertains to your child)**

Yes	No	Responsive to people	"Bang" his head on crib, chair or floor	Yes	No
Yes	No	Especially alert to movements	Eat well	Yes	No
Yes	No	Sensitive to vibratory sensations	Sleep well	Yes	No
Yes	No	Highly distractible	Cry, sob, shed tears	Yes	No
Yes	No	Behavior consistent from day to day	Upset when separated from parents	Yes	No
Yes	No	Laugh, smile, seems happy	Playful with children, adults and pets	Yes	No
Yes	No	"Stares" at lights, objects, people, and in	Rocks head while sitting/ standing	Yes	No

VIII. HEARING

1. Do you suspect any hearing difficulty?_____

2. Has your child's hearing been tested? If yes, When? Where? Results?

_____

3. Has your child been diagnosed with a hearing impairment? _____ If yes, by whom and when; please describe hearing loss that has been diagnosed: _____

_____

4. How do you get the child's attention when his back is turned away? _____

5. Does your child: (Please circle "yes" or "no")

Yes	No	Respond to any Sound	Seem to hear but not understand	Yes	No
Yes	No	Ask to have words repeated	Show fear of any sound	Yes	No
Yes	No	Respond to doorbell, airplane, horns	Trained in sign language	Yes	No
Yes	No	Respond Consistently	Wear a hearing aid	Yes	No
Yes	No	Ignores sound willfully	Gesture to communicate	Yes	No

IX. SPEECH AND LANGAUGE DEVELOPMENT (please write "yes" or "no")

Please answer yes or no to the following: When did/ Does the child: (please indicate the age where appropriate)

Yes	No	Babble Age:_____	Attempt to imitate speech Age:_____	Yes	No
Yes	No	Use Jargon Age:_____	Demonstrate understanding of speech	Yes	No
Yes	No	Vocalize for pleasure	Have a "language of his own"	Yes	No
Yes	No	Communicate by crying, laughing smiling	Seem to have "lost" any amount of language in the last couple of months	Yes	No
Yes	No	Use gestures meaningfully	Gesture to communicate	Yes	No
Yes	No	Refuse to use voice	Have difficulty pronouncing words? Please list sounds_____		
Yes	No	Have awareness of speech difficulties	Have any problems with their voice	Yes	No

Check the way your child most frequently communicates:

- ☐ Words, phrases, complete sentences
- ☐ Looking at objects
- ☐ Pointing to objects
- ☐ Physical Manipulation
- ☐ Sign Language
- ☐ Other:_____

IX. AUDITORY PROCESSING

1. Can your child understand directions/and or conversation: ____ yes ____ no

If "no", what behaviors have you observed? _____

_____

2. Has your child been diagnosed with an auditory processing disorder? ____ yes ____ no

XI. EDUCATIONAL HISTORY

1. Name of school presently attending: _____

2. Grade or level: _____

3. Describe general progress and behavior in school: _____

_____

4. Is the child in special class or receiving tutoring for any reason? If so, specify where and for what reason:

_____

5. Does your child display preference for any learning style over another? ____ visual ____auditory _____tactile

XII. ADDITIONAL PARENT COMMENTS

Please provide your personal observations relative to the child's speech/language and/or hearing and behavior:

_____

_____

_____

_____

Completed by: _____ Relationship to client: _____

Signature: _____Date: _____

HIPAA - Your Privacy Rights

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.

Effective date: _____

Creative Therapy Works, LLC is required by law to keep your health information safe. This information may include:

- notes from your doctor, teacher, or other health care provider
- your medical history
- your test results
- treatment notes
- insurance information

A government rule, called the Health Insurance Portability and Accountability Act, or HIPAA, requires that you get a copy of this privacy notice. We will ask you to sign a paper saying that you have been given this notice.

Read and refer to this notice at any time to see how your health information can be used and who can see it.

How Your Health Information May Be Used or Shared

We may use or share your health information without your permission for the following reasons:

- **Treatment.** We may share information with doctors and other health care providers who care for you. For example, if your doctor orders speech therapy, we will share the results of our treatment with that doctor.
- **Payment.** We may use and share information about the treatment you receive with your insurance company or other payer to receive payment for services. This may include sharing important medical information. We may share information to:
  - get the insurance company's permission to start treatment
  - get permission for more treatment
  - get paid for the treatment you receive

- **Health Care Operations.** We may use and share your health information to run the clinic and be sure that all patients receive good care. For example, we may use your health information to:
    - see how well our services are working
    - see how well our staff is doing
    - see how we compare to other clinics
    - make our services better
    - help others study health care services

Your Health Information May Also Be Used or Shared <u>Without</u> Your Permission for:

- **Abuse and Neglect.** We may share your health information with government agencies when there is evidence of abuse, neglect, or domestic violence.
- **Appointment Reminders.** We will use your information to remind you of upcoming appointments. Reminders may be sent in the mail, by e-mail, or by phone call or voicemail message. If you do not wish to get reminders, please tell your speech-language pathologist.
- **As Required by Law.** We will share your information when we are told to do so by federal, state, or local law. We will also share information if we are asked by the police or courts.
- **Government Functions.** Your information may be shared for national security or military purposes. If you are a veteran, your information may be shared with the Office of Veteran's Affairs.
- **Information About a Person Who Has Died.** We may share information with the coroner, medical examiner, or a funeral director, as needed.
- **Marketing.** We may use your information to let you know of other services that might be of interest to you.
- **Public Health Risks.** We may report information to public health agencies as required by law. This may be done to help prevent disease, injury, or disability. It may also be done to report medical device safety issues to the Food and Drug Administration and to report diseases and infections.
- **Regulatory Oversight.** We may use or share your information with agencies overseeing health care. This may include sharing information for audits, licensure, and inspections.
- **Research**. We may share your health information with researchers to be included in their research project. Information will be shared only for projects that have been through a special approval process. These projects have rules to protect your privacy, too.
- **Threats to Health and Safety.** Your health information may be shared if we believe that it will prevent a threat to your health and safety or the health and safety of others.
- **Worker's Compensation.** We will share your information with Worker's Compensation if your case is being considered as a work-related injury or illness.

When Your Permission Is Needed to Use or Share Your Health Information

You must give us permission to use or share your health information for any situation that is not listed in this notice. You will be asked to sign a form, called an authorization, to allow us to use or share your information. You are allowed to take back this authorization, called revoking

authorization, at any time. We will not be able to get back the information that we shared with your permission.

Your Privacy Rights

You have the right to:

- **Ask us not to share your information.** You can ask us not to use or share your information for treatment, payment, or health care operations. You can also ask us not to share information with people involved in your care, like family members or friends. You must ask for limits in writing. We must share information when required by law. We do not have to agree to what you ask.
- **Ask us to contact you privately.** You can ask us to contact you only in a certain way or at a certain place. For example, you may want us to call you but not to e-mail you. Or you may want us to call you at work and not at home. You must ask us in writing. We will do all we can to do what you ask.
- **Look at and copy your health information**. You have the right to see your health information and to get a copy of that information. You have a right to see treatment, medical, and billing information. You may not be able to see or copy information put together for a court case, certain lab results, and copyrighted materials, such as test protocols.
- **Ask for changes to your health information**. You can ask us to change information that you think is wrong. You can also ask that we add information that is missing. You must ask us in writing and give us a reason for the change. We do not have to make the change.
- **Get a report of how and when your information was used or shared.** You can ask us to tell you when your information was shared and who we shared it with. There are some rules about this:
    - You need to ask us in writing.
    - You must tell us the dates you are asking about and if you want a paper or electronic copy.
    - You may get information going back 6 years, but it cannot be for earlier than April 14, 2003. This is the date when the government privacy rules took effect.

- **Get a paper copy of this privacy notice.** You can get a paper copy of this notice at any time. You can get a copy even if you have already signed the form saying you have seen this notice.
- **File complaints.** You can file a complaint with us or with the government if you think that
    - your information was used or shared in a way that is not allowed
    - you were not allowed to look at or copy your information
    - any of your rights were denied

Who Is Covered by This Notice

The people who must follow the rules in this notice are:

- all speech-language pathologists working at Creative Therapy Works, LLC
- anyone who is allowed to add health information to your file, including students and other staff
- any volunteers who may help you while you are in this clinic

Changes to the Information in This Notice

We may change this notice at any time. Changes may apply to information we already have in your file and to any new information. Copies of the new notice will be available from our staff. The notice will have a date on the front page to tell you when it went into effect.

Complaints

You may file a complaint if you think we did something wrong with your information. You can complain to your regional office of the United States Office of Civil Rights. To find out more about filing complaints, go to www.hhs.gov/ocr/privacy/hipaa/complaints/index.html. All complaints must be in writing. You will not get in trouble for filing a complaint.

Contacts

If you have any questions about this notice or your privacy rights, please ask your speech-language pathologist or contact [insert contact name and information here].

Acknowledgment That You Have Received Our HIPAA Privacy Notice

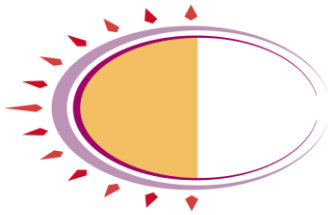
Creative Therapy Works, LLC is required by law to keep your health information safe. This information may include:

- notes from your doctor, teacher, or other health care provider
- your medical history
- your test results
- treatment notes
- insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information may be used and shared. It also tells you how you can look at and comment on your information.

By signing this page, you are saying that you have been given a copy of our privacy notice.

Print Patient's Name	Date
Patient or Parent/Guardian Signature	Relationship to Patient



...creating therapy that WILL work for YOU!

Attendance Policy

Thank you for choosing Creative Therapy Works, LLC. We want to provide the best possible services to all of our patients. We will do our best to schedule appointments that meet your needs. Regular attendance is important to you/your child's success. We ask that you follow the attendance policies outlined below:

1. **Cancellations:** Please call us at least 24 hours in advance to cancel your appointment. We reserve the right to charge a $25.00 fee if you do not give us 24 hours notice. Insurance will not cover this fee.
2. **Missed Appointments:** If you cancel or do not attend 2 sessions in a row, we will put your services on hold until scheduling conflicts can be worked out.
3. **Late for Appointments:** If you are more than 15 minutes late for your appointment, we reserve the right to reduce the treatment by the number of minutes late and/or cancel the appointment and consider it a missed appointment (see policy for missed appointments above). If you are late for 2 or more sessions, we may put your services on hold until scheduling conflicts can be worked out.
4. **Clinician Cancellations:** If your therapist is not able to attend your appointment, you will be contacted as soon as possible. Please be sure that our office knows the best way to reach you. Every effort will be made to reschedule your appointment in a timely manner.

To cancel an appointment, call our office at 866-611-7855

or e-mail Christine@creativetherapyworks.com

☐ I agree to the attendance policies outlined above.

Print Patient's Name _____ Date _____

Patient or Parent/ Guardian Signature _____ Relationship to Patient _____

Authorization for Release of Information

I give Creative Therapy Works, LLC permission to use or share my health information with:

_____

The information that will be used or shared includes (check all that apply):

- ☒ My medical records
- ☒ My treatment records (progress notes, daily records)
- ☒ My speech, language, or swallowing test results
- ☐ Other: _____

This information is being used or shared because:

It is needed for billing, authorizations and communication with medical doctor about treatment

This authorization will expire:

☐ On: _____ (date)

☐ After the following event happens: Discharge from Therapy Services

I understand that:

- I do not have to sign this authorization. I will still be able to get treatment here even if I do not sign it.
- I am allowed to see or copy the health information that will be used or shared.
- I can take back this authorization at any time. I need to write to Creative Therapy Works, LLC to do this.
- Any information that was used or shared before I took back the authorization cannot be returned.
- The person or organization that gets my health information because of this authorization may have the right to share it with others without my permission.

_____ _____

Print Patient's Name Date

_____ _____

Patient or Parent/Guardian Signature Relationship to Patient

Treatment Authorization

I agree to allow Creative Therapy Works, LLC to provide speech-language pathology services for my child. In addition:

- ☐ I have seen and agree with the treatment goals and therapy plan.
- ☐ I agree to attend scheduled therapy sessions (see attendance policy).
- ☐ I agree to participate in my child's/loved one's treatment, as appropriate.
- ☐ I understand that my child/loved one may be given work to do at home. I agree to help my child/loved one do this work to help with treatment goals.

Print Patient's Name	Date
Patient or Parent/Guardian Signature	Relationship to Patient