PATIENT INFORMATION

Child's Name: ___________________________ DOB: ______________________
Address:________________________________ Phone: ___________________
___________________Zip:_______ School: ____________________

Father's Name: _________________________ DOB: ______________________
Occupation: ___________________________ Social Security #:_____________
Phone: (work)__________________________ (mobile)_____________________
Email Address: ________________________

Mother's Name: ________________________ DOB: ________________________
Occupation: ___________________________ Social Security #: _____________
Phone: (work)__________________________ (mobile)______________________
Email Address: ________________________

Emergency Contact: ____________________ Phone: _______________________
Relationship to Patient: ____

Other Children in Home	Age	Relationship
____________________	_____	__________
____________________	_____	__________
____________________	_____	__________

Other Adults in Home	Age	Relationship
____________________	_____	__________
____________________	_____	__________

Primary language spoken in home: _______________________________
Other languages spoken in home: _______________________________

Reason for referral / Primary concern:
____
____

How did you find us?
Physician Friend Insurance Internet School Other____________
____

Person responsible for payment: ____

HEALTH HISTORY

Patient Name ____________________________ Today's Date ____________________
Person Completing History ____________________Relationship to Patient___________
Current Health Status ______________________ Date of Last Physical Exam __________
Primary Care Physician ____________________ Phone ____________________________
Other healthcare providers _________________________Phone ____________________

Prenatal and Birth History

During this pregnancy, did mother experience any unusual illness, condition, or accident, such as German Measles, Rh incompatibility, anemia, bleeding, diabetes, etc. If so, please describe: ____
____
____
____

Length of pregnancy: ____

Were there any problems with the delivery, such as breech birth, induced, interrupted, etc. If so, please describe: ____
____
____
____

Birth Weight: ____

Has your child ever been hospitalized? Yes No If yes, when? __________________
What was the reason for the hospitalization? ___________________________________
____

Has your child had any other significant illnesses, injuries, or surgeries? _____________
____

Please list all medications your child is currently taking: ___________________________
____

If your child has allergies, have specific allergens been diagnosed? _________________
____

Please list any specific food allergies: ____
____

Diseases	Age	Severity	Change in Speech
Chicken Pox			
Measles			
Scarlet Fever			
Rheumatic Fever			
Pneumonia			
Influenza			
Asthma			
Diphtheria			
Encephalitis			
Mumps			
Meningitis			
Whooping Cough			
Allergies			
High Fever (104+)			
Ear Infections			
Seizures			

Prior Evaluations

	Date	Results
Speech/Language	___________	_________________________________
Occupational Therapy	___________	_________________________________
Physical Therapy	___________	_________________________________
Hearing	___________	_________________________________
Vision	___________	_________________________________
Neurological	___________	_________________________________
Psychological	___________	_________________________________
Other	___________	_________________________________

Please provide previous evaluation reports from other professionals or provide facility and/or name of evaluator to request records. This information may be helpful in assessing and planning of treatment for your child.

Is there any additional information that will help us to better understand your child?

____
____
____
____
____
____
____
____
____

INSURANCE INFORMATION

PATIENT INFORMATION

Patient Name:	Date of Birth:	Sex: M F

RESPONSIBLE PARTY INFORMATION

Name:	Relationship:	
Address:	Sex: M F	
City:	State:	Zip:
Home Phone:	Work Phone:	
Social Security No:	Employer:	

INSURANCE COMPANY INFORMATION

Primary Insurance Co:	I.D. Number:	
Group Number:	Policy Number:	
Address:	City:	Zip:
Phone:		
Subscriber's Name:	Employer:	
Relationship to Patient:	Date of Birth:	
Secondary Insurance Co:	I.D. Number:	
Group Number:	Policy Number:	
Address:	City:	Zip:
Phone:		
Subscriber's Name:	Employer:	
Relationship to Patient:	Date of Birth:	

RELEASE OF MEDICAL INFORMATION

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original.

Date: Signature:

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to signed physician or supplier for services described on health insurance claim forms. I also understand that this assignment of benefits is irrevocable and a photo static copy shall be considered as legal and binding as the original.

Date: Signature:

PAYMENT POLICY

All payment for professional services rendered are due at time of service, unless insurance is applicable. We will file insurance, but all co-pays, co-insurance, and deductibles are due at time of service. Services not covered and balances remaining will be billed to the responsible party.

Date: Signature:

Patient's Name: ______________________________
DOB: ________________

Authorization for releasing and acquiring information:
I, the undersigned, authorize Capital Therapy Group, to acquire and/or release professional information from and to my child's physician and/or other personnel involved in the evaluation and management of requested services.

____
Signature of Parent/Guardian

____
Relationship to Patient

____
Date

Authorization for audio recording and/or videotaping:
I grant permission for my child to be videotaped and/or audio recorded during a therapy session. I understand that this video/audio recording will be used to establish baseline criteria for my child and may be analyzed at any time by my child's speech therapist, occupational therapist, and physical therapist. Audio and/or video recording *will not be shared with any other parties and will only be used for the purpose of analyzing skills for therapy goals*.

____
Signature of Parent/Guardian

____
Relationship to Patient

____
Date

SCHEDULING PAYMENT AND INSURANCE POLICIES

SCHEDULING:

24 Hour Cancelations:

Your scheduled therapy time is a reserved time for your child and therapist. Your therapist spends a great deal of time and effort preparing for your child's therapy session. If you must cancel a therapy session, we ask that you give at least 24 hours notice. ***Less than 24 hours notice for cancellations (last minute cancellations) and not showing up for an appointment (no shows) will be charged a $40 fee. These charges will not be filed with your insurance company and will be your full responsibility for payment.***

Consistency in Treatment:

Consistency in therapy attendance is absolutely necessary for your child to make progress. If you find it necessary to cancel therapy sessions frequently, we will ask that you schedule therapy at a more convenient time so that therapy may be provided on a consistent basis. If 3 of 5 scheduled appointments are cancelled or more than 2 scheduled appointments are missed due to a no show, all appointments will automatically be cancelled and your child will be put on a wait list until attendance can be consistent.

There will be times when your child's therapist will need to cancel therapy. To avoid unnecessary absences, whenever possible, we will have another therapist treat your child. The session will follow the usual therapy session and focus on the same goals.

Promptness:

The length of the therapy session is based on recommendations made to achieve the most during the session. Please be on time for your appointment. If you are late for an appointment, it will be necessary to shorten your child's therapy visit for that session to stay on schedule for the other patients.

Session End:

The last few minutes of each therapy session will be reserved for you to ask questions and/or for your therapist to review your child's session. We are always happy to visit with you about your child, but if you need to visit with your therapist for longer than this time allows, please schedule a separate consultation time. We ask that you be courteous of other patients and not expect your therapist to answer your questions during another patient's scheduled time.

Any questions or concerns you may have regarding your child's therapy or other issues or questions regarding office policies, may be directed to Susan Weber via phone at 512-331-4115 or via email at sweber@austinctg.com.

____

Parent/Guardian Signature   Date

PAYMENT:

Payment is due at the time services are rendered. If you are paying a co-payment or private payment, that payment is due at each visit. You may elect to pay weekly or monthly and can do so by discussing payments with the front desk.

If payment is not received from your insurance company within 60 days of billing, you will be responsible for payment in full.

Please note there will usually be a 4 week delay between the date services are rendered and the response from your insurance company. This delay is due to the time it takes your insurance company to process claims filed. Therefore, your statement will reflect this delay. Questions regarding insurance claims, charges and payments should be directed to Sylvia Johnson by phone at 512-331-4115 or by email to Sylvia Johnson via phone at 512-331-4115 or via email at sjohnson@austinctg.com.

____

Parent/Guardian Signature   Date

INSURANCE:

Insurance is a contract between you and your insurance company. Capital Therapy Group will file insurance claims and provide assistance in filing necessary paperwork when claims are denied but ultimately terms of reimbursement are between you and your insurance company. If for any reason, insurance does not reimburse at the anticipated rate, the patient is responsible for all expenses incurred.

New insurance?

If you change insurance companies, it is your responsibility to let CTG know and to provide a copy of the new insurance card on or before that new coverage begins. Failure to give the necessary information on or before coverage begins may result in your responsibility for all fees incurred for services provided during that time. Questions regarding your coverage, benefits and denials should be directed to your insurance company.

____

Parent/Guardian Signature   Date

CAPITAL THERAPY GROUP

Acknowledgement Of Receipt Of Notice Of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices.

____
Print Name

____
Signature

____
Relationship to Patient

For Our Office Use Only

Our office attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained for the following reason:

_______ Patient refused to sign
_______ Communication barriers prohibited obtaining the acknowledgement
_______ An emergency situation prevented us from obtaining acknowledgement
_______ Other (Describe below)
____
____
____

CAPITAL THERAPY GROUP

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this Notice please contact our Privacy Officer.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. We are required by Federal law to give you this Notice and to maintain the privacy of your health information. We must also abide by the terms of this Notice while it is in effect. We reserve the right to change our privacy practices and the terms of this Notice at any time. Before we make significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request.

Uses and Disclosures of Protected Health Information

You will be asked to sign an **Acknowledgement of Receipt Of Notice Of Privacy Practices.** Once you have received our Notice of Privacy Practices, disclosures of your protected health information will be used for treatment, payment and health care operations. Your protected health information may be used and disclosed by 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. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of practice. Following are examples of the types of uses and disclosures of your protected health care information that our office is permitted to make.

Treatment: We will use and disclose your protected health information to other health care providers to provide, coordinate, or manage your health care. For example, your protected health information may be provided to another health care provider to whom you have been referred to ensure that the necessary information is available to diagnose or treat you.

Payment: Your protected health information will be used to obtain payment for services we provide to you. This may include certain activities that your insurance plan may undertake before it approves or pays for the services we recommend.

Healthcare Operations: We may use or disclose your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, credentialing activities, conducting training and conducting other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your provider. We may also call you by name in the waiting room when your speech pathologist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointments.

Business Associates: We will share your protected health information with third party Business Associates that perform various activities (billing services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the

services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that our practice has already taken an action as provided for in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then we may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Family and Friends: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information to the extent necessary to help with your healthcare or with payment for your healthcare. We will also use our professional judgment to make reasonable decisions in your best interest in allowing a person to pick up health forms of health information.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent

Required By Law: We may use or disclose your protected health information when we are required to do so by law.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your Acknowledgement of Receipt Of Notice Of Privacy Practices as soon as reasonably practicable after the delivery of treatment. In the event of your incapacity or an emergency, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim or other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health and safety of others.

Military Activity and National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody, the protected health information of inmates or patients under certain circumstances.

Required Uses and Disclosures: 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.

Your Rights

You have the right to inspect and copy your protected health information. You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make the request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you prefer, we will prepare a summary or an explanation of your health information for a fee.

You have the right to request a restriction of your protected health information. You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in an emergency.

You have the right to request alternative communications from us. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

You have the right to request an amendment to your health information. You have the right to request that we amend your health information. Your request must be in writing. The request must explain why the information should be amended. We may deny your request under certain circumstances.

You have the right to receive an accounting of disclosures we have made of your health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost based- fee for responding to these additional requests.

You have the right to make a complaint about our privacy policies. If you are concerned that we have violated your privacy rights, you may file complaint with our Privacy Officer using the contact information listed at the bottom of this page. You may also file a written complaint with the Department of Health and Human Services. We will provide you with their address upon request. We will not retaliate against you for making a complaint to either our office or the Department of Health and Human Services.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Effective Date: January 21, 2013

Privacy Officer: Susan Weber

Telephone: (512) 331-4115

Fax: (512) 331-8176

Email: info@austinctg.com

Address: 13642 North Highway 183, Bldg. 2, Ste. 200