Marcimouth Speech and Language Services, INC.
12777 W Forest Hill Blvd Suite 1503 Wellington FL 33414
561-790-1864(Phone)
561-429-3081 (fax)

CHILD CASE HISTORY

Please fill out this form as completely as possible, if you need more space, attach another page, or write on the back. Call 790-1864 if you have additional questions regarding this form

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Patient Information

Date:_____
Patients Name: _____ Date of Birth_____
Gender: F_____ M_____
Phone: (home)_____ (cell)_____ (work)_____
Physician Name_____ Phone number_____
Best time to call: _____ Email:_____
Address:_____
City: _____ State:_____ ZIP:_____
*****Reason for referral: _____
Referring person:_____

Other Professional seeing your child?
Name:_____
Address:_____ Phone_____

Parent Information

Mother/Guardian_____ Social Security Number_____
Place of Employment _____ Phone Number_____
Father/Guardian _____ Social Security Number_____
Place of Employment_____ Phone Number_____
Email:_____

Diagnosis Information

Primary _____ Secondary_____
What are the problems?_____
_____

Insurance Information

Insurance Carrier: _____, ID #_____
Group #_____ Insurance Carrier phone#_____ Policy holder name_____ Relationship to Patient_____
2nd Insurance Carrier (If there is one)_____ ID #_____
Group #_____ Insurance Carrier phone#_____ Policy holder name_____

Assignment and Release

I, the undersigned, certify that I or my dependent, has insurance coverage with _____ and assign directly to Marcimouth Speech & Language Services all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I authorize the use of this signature to release medical records to primary physician and/or Health Insurance Company.

_____

Responsible Party's Signature **Relationship** **Date**

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Health History

Birth History
***D**ifficulties during pregnancy, labor, or delivery?_____
_____
What was mother's age at delivery:_____ and general health: _____
Length of Pregnancy: _____ C-section_____ Vaginal_____
Weight at birth_____ Apgar Score_____
Did your child have any of the following at the birth: Jaundice? Y N Cyanosis? Y N Rh incompatibility factors? Y N

Medical History for child
***P**lease mark if and when you have had any of the following:
___ Seizures ___ High fevers ___ Measles ___ Mumps
___ Chicken pox ___ Whooping cough ___ Diphtheria ___ Bronchitis
___ Pneumonia ___ Tonsillitis ___ Meningitis ___ Encephalitis
___ Rheumatic fever ___ Tuberculosis ___ Sinusitis ___ chronic colds
___ Enlarged glands ___ Thyroid ___ Asthma ___ Heart trouble
___ Chronic Laryngitis ___ Diabetes ___ Head injuries

For items marked above, give the relevant details (e.g., how frequent and/or how severe are these episodes?):
_____
_____

Recurrent earaches/ear infections? Yes___ No ___ If yes Describe:_____
Are immunizations current? _____ Current general health_____
_____

Allergies? (Describe)_____

Any other serious or recurrent illnesses YES NO Date(s)_____

Any operations YES NO Date(s):_____

Any accidents YES NO Date(s)_____

Any medications YES NO (Past)_____
(Current)_____

***H**earing difficulties YES NO If yes describe_____
_____

Vision problems YES NO Treatment:_____

Dental problems: YES NO Treatment:_____

Other: Left or right handed_____

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Family History:

Names and ages of other children:_____

***Any speech or hearing problems in the family YES NO If yes Explain:_____
_____
_____

Speech and Language:

Are there concerns regarding early speech and language development YES NO
If yes Describe:_____
_____

Other language(s) spoken in the home:_____

Has your child ever had difficulty understanding or expressing him/herself YES NO Describe:_____
_____
_____

***What are your child's communication needs in social settings _____
_____
_____

***What difficulty does your child have meeting their communication needs
_____
_____
_____

Educational History

Any Schools that the child has
attended:_____
_____

***How did or does your child's communication difficulty affect his/her performance in
school_____
_____
_____

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Attendance Policy

While Marcimouth Speech and Language understands that appointments cannot always be kept, the following policy is in place. Please give at least 24 hours' notice when cancelling an appointment, if sufficient time is not given and you have Medicaid/Medipass, or CMS/title 21 insurance, we cannot charge you a no-show fee. The office is implementing a 3 missed appointments in any given month, and a 2 time no show/no call procedure. You must give advance notice when missing an appointment or you will be discharged from therapy services.

Marci Chaves, MS CCC-SLP
Owner/operator
Marcimouth Speech & Language Pathologist
12777 W Forest Hill Blvd
Suite 1503
Wellington, FL 33414

_____

Parents/Guardians Signature Child's Name Date

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General Attendance Policy

While Marcimouth Speech and Language understands that appointments cannot always be kept, the following policy is in place. Please give at least 24 hours' notice when cancelling an appointment, if sufficient time is not given you will be charged a cancellation fee of up to 25.00. In case of an emergency, I agree to notify Marcimouth Speech and Language Services at least 24 hours in advance when possible to cancel/reschedule an appointment.

_____

Parents/Guardians Signature Child's Name Date

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Payment for Therapies Evaluation/Screening

Please be advised that if your child is screened for therapy and it is determined that intervention is needed, an evaluation is required prior to treatment. The fee for the evaluation is based on the time it takes for the therapist to write it up, in addition to the actual testing time. If you wish to bill your insurance company a prescription from your pediatrician is needed prior to arriving for the evaluation. Although a prescription is not required by law, most insurance companies require it before processing the claim.

I have read and fully understand the above statement.

Parents/Guardians Signature Child's Name Date

Patient Acknowledgment of Receipt of Notice of Privacy Practices

Please Print

I, _____, hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or complaints, I may contact:

_____

_____

_____

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient or Personal Representative

Signature: _____ Date: ____/____/____

Name: _____
Please Print

Relationship to Patient: _____

For Office Use Only

We made a good-faith effort to obtain an acknowledgment of _____'s receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

☐ Patient refused to sign (date of refusal) ____/____/____.

☐ Communications barriers prohibited obtaining an acknowledgment.

☐ An emergency situation prevented us from obtaining an acknowledgment.

☐ Other _____

Attempt was made by: _____ Date: ____/____/____