Grovetown: 706-842-3330
5176 Wrightsboro Road, Grovetown, Ga 30813

Evans: 706-842-3330
536 Grand Slam Drive, Ste D, Evans, Ga 30809

Child Intake & Case History Form

IMPORTANT!
If your child has an **IEP, IFSP, or 504 Plan** the front office is **required to have a copy of this for insurance approval purposes**. In addition, speech therapy patients with Georgia Medicaid, Amerigroup, Caresource, or Peachstate insurances must submit a recent **hearing screening** to the front office. All patients must submit a **copy of the insurance card** – front and back.
Without a copy of these items, therapy may be delayed.

Personal Information:

Child's Name:				☐ Male	☐ Female
Date of Birth:				Age:	
Parents/Guardians:					
Address:					
City:		State:		Zip Code:	
Phone #1:		Phone #2:			
Email Address:					
Child Lives With:	☐ Birth Parents ☐ Adoptive Parents ☐ Foster Parents ☐ Parent & Step-Parent ☐ One Parent ☐ Other:				
Other Children in the Family:	Name: _____ _____ _____ _____	Age: _____ _____ _____ _____			
Is there a language other than English spoken in the home?	☐ Yes ☐ No	If "yes", which one?			
		Does the child **speak** the language?	☐ Yes ☐ No		
		Does the child **understand** the language?	☐ Yes ☐ No		

Medical Information:

Doctor's Name:		Phone #:	
Other Physicians:		Phone #:	
Specialists Seen:			
Diagnoses Given (if any):			
Has the patient received an **evaluation or therapy within the last 6 months**?	☐ Yes ☐ No	If YES, please describe **when and where**:	
Please describe and date any injuries, hospitalizations, or surgeries involving the patient:			

Insurance & Billing: **Must provide copy of insurance card – front and back

Insurance Name:		Effective Dates:	
Policyholder Name:		Policyholder Date of Birth:	
Policy #:		Group #:	
Secondary Insurance:		Effective Dates:	
Policyholder Name:		Policyholder Date of Birth:	
Policy #:		Group #:	

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Developmental & School History

Patient Name:		**Date of Birth:**	

Patient History:

Was patient born premature:	☐ Yes ☐ No	If so, how many weeks?	
List any complications during pregnancy or birth:			
Does the child have any significant health problems?	☐ Yes ☐ No	If so, please describe:	
Please check all conditions that apply to the patient:	___ Meningitis ___ Seizures ___ Vision Impairment ___ Neuro Disorder ___ TBI	___ ADD/ADHD ___ Cerebral Palsy ___ Autism ___ HIV ___ Cleft Palate ___ Other:	___ Asthma ___ Hearing Impairment ___ Acid Reflux ___ Fragile X
	___ Down Syndrome ___ Apraxia ___ Stroke ___ Intellectual Disability		
Is the child on any medications?	☐ Yes ☐ No	Please list:	

Patient Background:

Behavior Characteristics: *(Check all that apply)*	___ Cooperative ___ Attentive ___ Willing to try new activities ___ Plays alone well ___ Separation Difficulties	___ Easily Frustrated ___ Stubborn ___ Restless ___ Poor Eye Contact	___ Easily Distracted ___ Destructive/Aggressive ___ Withdrawn ___ Inappropriate Behavior ___ Self-Abusive Behavior
Please list the **ages** the following milestones were achieved:	_____ Saying first words _____ Speaking in phrases	_____ Sitting alone _____ Crawling _____ Walking	_____ Using the potty
Do you feel like your child has a **speech** problem?	☐ Yes ☐ No	Do you feel like your child has a **feeding** problem?	☐ Yes ☐ No
Do you feel like your child has a **hearing** problem?	☐ Yes ☐ No	Does your child **choke** on foods or liquids?	☐ Yes ☐ No
Does your child **put toys or objects** in his/her mouth?	☐ Yes ☐ No	Does your child allow his/her **teeth to be brushed**?	☐ Yes ☐ No
Please describe your answers from above:			

Problems & Goals:

Caregiver's description of **problem**:	
Caregiver and patient's **goal** for therapy:	

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Patient Name:		**Date of Birth:**	

School and Other Services:

Does the child receive **Babies Can't Wait** Services?	☐ Yes ☐ No	If yes, what services:	☐ PT ☐ OT ☐ Speech ☐ Special Instruction
		If yes, who is your service coordinator?	
Does the child have an **IEP** or **504 Plan** (through school) or **IFSP** (through Babies Can't Wait)?	☐ Yes ☐ No	If yes, what services:	☐ PT ☐ OT ☐ Speech ☐ Other: _____
Does your child attend school or daycare?	☐ Yes ☐ No	If yes, what grade:	
Is your child **homeschooled**?	☐ Yes ☐ No	Name of school/daycare:	
		Name of Teacher:	
Has your child repeated a grade?	☐ Yes ☐ No	What are your child's strengths and/or best subjects?	
Is your child having difficulty or is receiving help in any subjects?			
Important! Please take note: IEP, IFSP, 504 Plan, & Intent to Homeschool	If you checked "yes" to your child having an **IEP**, **IFSP**, or **504 Plan**, please submit a copy to the front office. For homeschooled children, we must have a copy of the **Declaration of Intent to Homeschool**. ***These is required for insurance approval.*** If we do not have a copy, you understand that treatment may be delayed.		
Parent/Caregiver Signature: _____ Date: _____			

Policies:

Attendance & Cancelations	A *$25 fee* will be charged for late cancellations (less than 24 hours) or no-showing for an appointment. A "no-show" is defined as an appointment that is cancelled less than 3 hours before the scheduled time OR an appointment that is missed without warning. Three late arrivals to appointments (5-10 minutes later than scheduled time) will also to equate to 1 no-show appointment. ***The patient will be discharged or placed on a "flex plan" (week by week appointments) if 50% of scheduled appointments are cancelled, missed, or arrived late within 30 days.*** To avoid this fee or discharge from treatment, please cancel appointments as soon as possible and attempt to reschedule the missed session. Additionally, if you arrive late for a scheduled appointment, the session will still end at the scheduled time. Your late appointment will be canceled if you arrive more than 10 minutes late (for 30-min session) or more than 20 minutes late (for 60-min session).
Patient Safety	Every effort will be made to ensure the safety of our patients, families, and employees. To ensure their safety, Therapy Trails follows the restraint, seclusion, and safety protocol provided by the U.S. Department of Education (2012). Please ask the office for a copy of this article.
These policies are put in place in order for you and your child to have a successful experience at Therapy Trails! We look forward to working together to achieve success. Thank you for giving us the opportunity to work with you and your child! Parent/Caregiver Signature: _____ Date: _____	

If completing digitally, the parties agree that the electronic signature of a party to this Agreement shall be as valid as an original signature of such party and shall be effective to bind such party to this Agreement

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Patient Name:		**Date of Birth:**	

Consent for Services:

I authorize Therapy Trails to render appropriate evaluation and therapy services to the patient named below in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained health professional. I recognize, agree, and understand that I have the right to refuse treatment or terminate services at any time by Therapy Trails in writing. In addition, Therapy Trails may terminate services by notifying me according to my communication preference.

Parent/Caregiver Signature: _____ Date: _____

Communication Preferences:

I grant Therapy Trails permission to contact me using **voice call**, **text messaging**, **email**, and/or **mail**, unless otherwise specified in writing.	Additional Comments:

Parent/Caregiver Signature: _____ Date: _____

Consent and Release of Photographs and Videos:

Therapy Trails often uses photos and videos of patients in his/her therapy sessions, for purposes including but not limited to educational publication, for teaching purposes, promotional purposes (ex. Social media, website, etc.), and demonstration of progression of his/her skills. *[Check one below]*

☐ Yes, I give consent to Therapy Trails to photograph and/or video record the patient.
☐ No, I do not give consent to Therapy Trails to photograph and/or video record the patient.

Parent/Caregiver Signature: _____ Date: _____

Authorization to Release Information:

I grant Therapy Trails permission to communicate with the following person or agency:	☐ Family Members: _____ ☐ Pediatrician: _____ ☐ Other Medical Professionals: _____ ☐ Teacher: _____ ☐ Other: _____ ☑ Therapy Trails (Between ALL Locations)

I grant permission to exchange information via written and mailed report, phone call, meeting, email, or fax. I understand that unless revoked, this authorization will remain valid until written revocation of this authorization is presented.
In addition, I grant permission for Therapy Trails to communicate with each of their offices and share information (such as referrals, documentation, testing results, authorization, intake, demographics, etc.) between ALL their locations.

Parent/Caregiver Signature: _____ Date: _____

Financial Disclosures:

Payment Policy	Patients are responsible for all costs not covered by insurance. In the event that a third-party payer source determines that rendered therapy services are "not covered" or otherwise denied, patients will be responsible for all outstanding charges. If fees are not paid in full, treatment sessions may be postponed or cancelled until payment is received. ***Payments (including session fees and/or co-pays, if applicable) are due at the time of service.*** Overdue accounts may also be reported to a Credit Bureau. Refunds will be issued only in instances of overpayment.

I have read the above financial disclosures and policies. I understand that services at Therapy Trails may be terminated if payments are not received for unpaid services.

Parent/Caregiver Signature: _____ Date: _____

If completing digitally, the parties agree that the electronic signature of a party to this Agreement shall be as valid as an original signature of such party and shall be effective to bind such party to this Agreement

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Initial Evaluation Fee: At each initial evaluation, $150 will be required at check-in, regardless of insurance. Once the EOB is received, this payment will be applied toward deductible, co-pay, co-insurance, or any other outstanding balance. If insurance covers visits in full, this payment will be fully reimbursed. However, if insurance requests more than this amount, you will be billed for any remaining visit costs.

Insurance Policy: You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: (i) your health plan requires prior authorization or referral before receiving services at Therapy Trails, and you have not obtained such an authorization or referral; (ii) you receive services in excess of such authorization or referral; (iii) your health plan determines that the services you received at Therapy Trails are not medically necessary and/or not covered by your insurance plan; (iv) your health plan coverage has lapsed or expired at the time you receive services at Therapy Trails; or (v) you have chosen not to use your health plan coverage. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly.

Insurance Changes: If the patient's insurance plan changes, our front office and billing department must be notified immediately. Additionally, a copy of the new insurance card must be received by our staff. If Therapy Trails is not notified of the change in insurance plan or policy, the patient will be responsible for any cost incurred as a result. This may include, but not limited to; (i) your new health plan requiring prior authorization or referral; (ii) you receive services in excess of such authorization or referral; (iii) your new health plan determines that the services you received at Therapy Trails are not medically necessary and/or not covered by your insurance plan; or (iv) you have chosen not to use your health plan coverage.

Insurance Remittance: If your insurance carrier does not remit timely payment on your claim, you will be responsible for payment of the charges within the terms set forth herein. Once your insurance carrier processes your claim, we will bill you for any remaining patient responsibility deemed by your insurance carrier. If any payment is made directly to you for services billed by us, you agree to promptly submit same to Therapy Trails until your patient account is paid in full. If you make a payment that results in a surplus on your account, you authorize Therapy Trails to apply the overpayment to any other account for which you are financially responsible, including your account, a member of your family's or dependent's account, or on any account for which you are a Financial Responsibility Party, and any remaining balance will be returned to the payor.

(Financial Disclosures continued on next page with required signatures)

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Financial Disclosures
(Continued)

Estimated Costs: Our office may provide you with an estimated summary of anticipated costs. This is only an estimate of benefits. This is intended to be a "best-guess" as to what you will owe for visits. We will not know exact amounts until visits are billed (approximately 30–90-day turn-around). We recommend that you also speak with your insurance company to find out additional information. This estimate is based on the insurance company's web portal and does not guarantee that the patient's diagnosis or billed procedure codes are a covered service. The patient will still be responsible for any additional insurance costs that are not included on the estimated summary.

Outstanding Balances: If outstanding balances are left unpaid, you risk the patient being removed from the schedule until a payment is received. Any patient with a balance of $200 or greater will not be seen for any services until a payment is received.

Medicaid: If you are a Medicaid (or Medicaid CMO) patient, you must present a valid eligibility card at the time of registration and prior to the time of service. Without verification of coverage, you will be responsible for the full/entire balance of your account. As a courtesy to you, your account will be billed to Medicaid when we receive all necessary information. You are responsible for non-covered portions and spend-down requirements associated with your individual coverage. If at any time you are not eligible for Medicaid/CMO coverage and wish to be seen, you will be treated as a self-pay patient and must make payment at the time of service.

Acknowledgement

By signing below, each of the undersigned acknowledges that:

- **(i) I have been provided a copy of the Therapy Trails, Financial Disclosures Statement**
- **(ii) I have read, understand, and agree to their provisions and agree to the specified terms;**
- **(iii) I agree to pay all charges due (or to become due) to Therapy Trails for the below Patient's care and treatment, including co-payments and deductibles, as required or provided pursuant to my insurance plan and/or the insurance plan of another, as applicable;**
- **(iv) benefits, if any, paid by a third-party will be credited on the Patient account;**
- **(v) regardless of my insurance status or absence of insurance coverage, I am ultimately responsible for the balance on the account for any services rendered;**
- **(vi) if I failed to make any of the payment for which I am responsible in a timely manner, I will be responsible for all costs of collecting the money owed, including court costs, collection agency fees, and attorneys' fees (to the extent allowed by law); and**
- **(vii) failure to pay when due may subject me to late payment charges and can adversely affect my credit report.**

I further agree that a photocopy of this Patient Responsibility Financial Statement shall be as valid as the original.

ONCE I HAVE SIGNED THIS AGREEMENT, WHETHER BY ORIGINAL, FACSIMILE OR ELECTRONIC SIGNATURE, I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.

_____ _____

Patient's Name | Patient's Date of Birth

_____ _____

Responsible Party/Guardian's Signature | Today's Date

If completing digitally, the parties agree that the electronic signature of a party to this Agreement shall be as valid as an original signature of such party and shall be effective to bind such party to this Agreement

Therapy Trails LLC

GROVETOWN | EVANS | AUGUSTA

Documentation Required for Insurance

Authorization to Obtain

Most insurances require a hearing screening, IEP, IFSP, and/or 504 Plan for therapy authorization. These documents are also important to ensure we are coordinating care with other professionals.

Please completed this form to allow Therapy Trails to obtain your child's results and reports.

Child's Name: _____

Child's Date of Birth: _____

I grant permission for Therapy Trails to release and exchange information via written and mailed report, phone call, meeting, email, or fax to the following:
(Please select ALL that apply!)

Hearing Screenings

Hospital of Birth: _____

ENT/Audiologist: _____

Pediatrician: _____

Other: _____

IEP/IFSP/504 Plan

School: _____

County's Board of Education: _____

Babies Can't Wait (GA): _____

BabyNet (SC): _____

Other: _____

This authorization will remain valid until written revocation of this authorization is presented.

_____ _____

Parent/Guardian Signature Date

Therapy Trails LLC

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Acknowledgement That You Have Received Our HIPAA Privacy Notice

Therapy Trails is required by law to keep your health information and records safe. This information may include:

- Notes from your doctor, teacher or other healthcare provider
- Medical history
- 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.

Please initial:

_____ I acknowledge that I have received a copy of Therapy Trails HIPAA Notice of Privacy Practices that fully explains the uses and disclosures they will make with respect to my individually identifiable health information.

_____ I have had the opportunity to read the notice and to have any questions regarding the notice answered to my satisfaction.

_____ I understand Therapy Trails cannot disclose my health information offer than as specified in the notice.

_____ I understand that Therapy Trails reserves the right to change the notice and the practices detailed therein if it sends a copy of the revised notice to the address I have provided.

_____ _____

Print Name of Patient Date

_____ _____

Signature of Patient or Legal Representative Relationship to Patient

---

(For Office Use Only)

I tried to obtain written Acknowledgement of our Privacy Notice by the patient/legal representative noted above. It could not be obtained for the following reason(s)

- An emergency prevented us from obtaining acknowledgement.
- The individual was unwilling to sign.
- A communication barrier prevented us from obtaining acknowledgement.
- Other: _____

HIPAAA POLICY
NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. HIPPA
provides penalties for covered entities that misuse personal health information.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.
Treatment means providing, coordinating, or managing health care and related services, by one or more health care providers. An example of this would include a physical examination.
Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.
We may create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.
You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:
The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relative, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to obtain a paper copy of this notice from us upon request.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaints with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the polices and procedures of our office. We will not retaliate against you for filling a complaint.
Please contact the following for more information:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775