Columbus Therapy Associates
1335 Dublin Road Ste 200B, Columbus OH 43215 www.ColumbusTA.com p: 614-595-9037 TherapyTeam@ColumbusTA.com f: 614-448-4702

Case History

Date: _____

I. Identifying and Family Information:

Child's Name: _____ Birthdate: _____ Sex: ___ M ___ F

Parents'/Caregivers' Names: _____

Who is responsible for making medical decisions: ___ Mother ___Father ___Both ___Self
___Other (please specify): _____

Physical Address: _____ Mailing Address: _____
_____ _____
_____ _____

Phone: home _____ transportation _____
cell _____ *relationship/name of company:* _____
work _____

Email address: _____

Doctor's Name: _____ Doctor's Phone: _____

May we leave a message on your phone voicemail or email for appointment confirmations and cancelations?

___ Yes ___ No If Yes, please tell us which ones: _____

Person to contact in an emergency:
Name: _____ Relationship: _____
Phone #: _____ Additional Phone #: _____

Client lives with:

_____ Birth parents
_____ Foster parents
_____ One Parent
_____ Adoptive Parents
_____ Parent & Step Parent
_____ Other: _____

Adoption (complete if appropriate)

At what age was your child adopted? _____

Are you aware of any significant prenatal history of family and/or medical history of birth parents (ie. drug abuse, neglect, etc)? Please explain_____
_____
_____

Other children in the family:

Name	*Age*	*Sex*	*Grade*	*Developmental Delay?*

Are there languages other than English spoken in the home? ___ Yes ___ No
If yes, which one/s? _____
Does the child speak the language? _____ understand the language? _____

II. Medical Information:

Describe precautions regarding your child's care.

_____

_____

Please check if your child has ever had any of the following issues. If checked, please note dates and describe below.

Colic		Strep Throat		Food Tolerance		Allergies	
Seizures		Reflux		Operations		Skin Sensitivity	
Bronchitis		Asthma		Vision Problems		Eczema	
High Fevers		Measles		Pneumonia		Unconsciousness	
Blackouts		Vomiting		Physical Injuries		Diabetes	
Staring Spells		Hearing Problems		Sinus Infections		Lead Poisoning	
Motion Sickness		Ear Infections		Lung Difficulty		Other *(please specify)*	

Please explain checked items:

_____

_____

_____

Is your child on any medications? If yes, please list what kind and for what.

_____

_____

III. History of Intervention:

Has your child received other evaluations or treatment (neurologist, audiologist, psychologist, speech/language, OT, PT, etc.)?: ___ Yes ___ No

Type *Eval. Date* *Professional's Name* *Date of Therapy*

_____

_____

_____

When was your child's most recent hearing screening?: _____ Results: _____

When was your child's most recent eye exam? _____ Results: _____

Has your child ever been diagnosed as having any medical or psychological/educational conditions? ___ Yes ___No
If yes, please explain: _____
Who made this diagnosis and when was it made? _____ Date: _____

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IV. Pregnancy & Delivery:

During your pregnancy, did you:	Yes	No	Comment
have any infections/illnesses?	____	____	_____
have any shocks/unusual stresses?	____	____	_____
receive any medication?	____	____	_____
have any complications during delivery/labor?	____	____	_____

What was the weight at birth? _____ lbs. _____ oz.

How long was the labor? _____

Was your child:	Yes	No	Comment
full-term?	____	____	_____
premature?	____	____	*if so, what was the number of weeks?* _____
small for gestational age?	____	____	_____
breech (feet first)?	____	____	_____
require forceps at delivery?	____	____	_____
require suction/vacuum?	____	____	_____
delivered through Cesarean?	____	____	_____
have birth injuries?	____	____	_____
have cord problems?	____	____	_____
have meconium aspiration?	____	____	_____
in need of breathing assistance?	____	____	_____
in NICU for any period of time?	____	____	*if so, for how long?* _____
jaundice?	____	____	_____

V. Infancy & Early Development:

Does or did your child:	Yes	No	Comment
have feeding problems/difficulty with nursing?	____	____	_____
have sleeping problems?	____	____	_____
have colic?	____	____	*for how long?* _____
have difficulty calming?	____	____	_____
prefer certain positions as an infant?	____	____	_____
dislike lying on stomach?	____	____	_____
arch back when held and pull away?	____	____	_____
enjoy bouncing?	____	____	_____
become calmed by car rides/infant swings?	____	____	_____
become nauseated by car rides/infant swings?	____	____	_____
tend to always be generally compliant?	____	____	_____
go through "terrible twos?"	____	____	*for how long?* _____
have separation issues?	____	____	_____

At what age did your child achieve the following:

_____ sit independently	_____ roll over	_____ talk (first word)
_____ crawl (belly crawl)	_____ walk with support	_____ gesture & point
_____ crawl (on hands & knees)	_____ walk independently	

Was their crawling phase brief? (less than 2-3 months) _____

How much time was spent on the tummy? _____

Did your child particularly prefer or avoid any one position? Describe: _____
_____

Did your child gain age appropriate skills and then lose some of those skills? If yes, please describe: _____
_____
_____

VI. Diet/Nutrition:

	Yes	No	Comments
Is your child a picky eater?	____	____	_____
Does your child take any nutritional supplements?	____	____	_____
Is mealtime challenging for you and your child?	____	____	_____

Is your child's diet limited to:

____ dairy products ____ refined carbohydrates ____ diet is varied, not limited
____ soft foods ____ finger foods ____ avoids certain textures
____ tolerates a variety of textures
comments _____

	Yes	No	Comments
Is your child a sloppy eater?	____	____	_____
Does your child use silverware correctly?	____	____	_____
Does your child lack mouth skills to chew or swallow?	____	____	_____
Meal manners are expected in our home.	____	____	_____

Gastrointestinal history:

reflux _____
gas _____
constipation _____
diarrhea _____
difficulty with bowel control _____
bedwetting _____
vomiting _____

VII. Current Family Dynamics:

How well does your child organize daily tasks? _____
_____
_____

Describe your child's drive for independence. _____
_____
_____

How well does your child adjust to changes in routine? _____
_____
_____

How important is having a routine to your child's ability to get through the day? _____
_____
_____

Is your child's behavior significantly different outside the home? _____
_____
_____

Please describe the discipline techniques that you use and their effectiveness. _____
_____
_____

Please describe any repetitive behaviors *(ie. hand flapping, rocking, staring, head banging)* _____
_____
_____

What causes your child's frustration/anger/anxiety? _____
_____
_____

Is your child impulsive? _____
_____
_____

How have your child's difficulties affected your life? _____
_____
_____

What are you most concerned about? _____
_____
_____

What do you see as your child's most difficult problem in the home? _____
_____
_____

What do you see as your child's most difficult problem in school? _____
_____
_____

VIII. School History *(if applicable)*:

If your child is in school, please answer the following:

Name of school: _____

Teacher's Name: _____ Grade: _____

Is or has your child been in a special classroom and/or involved in special services? If yes, describe what type, when and where: _____
_____
_____

Please comment on information you have already received from your child's teachers regarding: peer relations, ability to sit in circle time, participation in group activities, sharing, snack time, nap time, etc.

_____
_____
_____
_____

Does your child participate in any playgroups or other groups involving children? Please explain _____
_____
_____

IX: Additional Information:

What do you hope to gain from this assessment/therapy? _____
_____
_____

Who referred you to our clinic: _____

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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 THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use or disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization

Abuse and Neglect, Judicial and Administrative Proceedings, Emergencies, Law Enforcement, National Security, and Public Safety (Duty to Warn)

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as state licensing boards or health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI: You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to our Privacy Officer, Jody Cane, at 1335 Dublin Rd, Suite 200B, Columbus OH 43215.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this Notice.
- **Electronic Transactions Standards.**

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Jody Cane, our Privacy Officer, at 1335 Dublin Road, Suite 200B, Columbus OH 43215, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling (202) 619-0257.

We will not retaliate against you for filing a complaint.

Please ask the front desk if you'd like a copy of this policy for your records.

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Client's Name: _____ Date of Birth: _____

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT OF POLICES REGARDING PRIVACY PRACTICES AT COLUMBUS THERAPY ASSOCIATES, LLC

In signing this document, I acknowledge that I have been notified of my right to privacy and been offered a copy of Columbus Therapy Associates, LLC notice of privacy practices.

Responsible Party Signature (Adult Client or Parent/Legal Guardian): _____

Responsible Party Printed Name (Adult Client or Parent/Legal Guardian): _____

Date: _____

Please ask the front desk if you'd like a copy of this policy for your records.

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Observation Authorization/Photo Release Form

Students of universities studying to enter the field of speech/language pathology or occupational therapy and members of a clients' treatment team may request to observe a client's session here at CTA. Each observer will be asked to sign a form accepting & agreeing to maintain confidentiality about all clients they see here in the clinic and any information they may learn about the client/s they are observing. This form serves to provide your, the client's caregiver/parent/legal guardian, permission for observations of therapy sessions here at CTA. Observations of sessions may also be declined. Permission for observations may be revoked at any time.

It is the policy of CTA that information about families treated must be kept confidential. Information about the client or their families may not be shared with anyone unless it is directly related to the case and prior written consent is given by the family. The Notice of Privacy Practices, to which all members, employees, volunteers, and students observing will adhere, has been signed by your child's caregiver/parent/legal guardian. A copy of each policy is kept in the filing cabinet.

Please complete the information below. This form is completed solely at the discretion of the client and/or parent guardian who is to be observed.

Non-Discrimination Policy: It is the policy of CTA to maintain a working environment free of all forms of unlawful discrimination. CTA, LLC affords equal opportunity to all employees and prospective employees without regard to race, color, sex, gender, sexual orientation, religion, age, marital status, disability, veteran status, or national origin or other criteria protected by law.

Please connect with CTA staff should you have additional questions.

Please check one (request can be revoked at any time):

_____ I authorize observation of _____ *(Client Name)*

_____ I DO NOT authorize observation of _____ *(Client Name)*

Photo/Video Release: Therapists may wish to photograph or videotape portions of therapy sessions to share with families or other professionals working with the client. Therapists taking these photographs and videotapes will do so using care for confidentiality & protection of Personal Health Information (PHI) of the client. They will be used for therapeutic purposes & will not be released to outside agencies without written consent. Photographs and videotapes will not be shared on social media platforms. Please check one (request can be revoked at any time):

_____ I authorize photographing/videotaping of _____ *(Client Name)*

_____ I DO NOT authorize photographing/videotaping of _____ *(Client Name)*

Responsible Party Signature (Adult Client or Parent/Legal Guardian): _____

Responsible Party Printed Name (Adult Client or Parent/Legal Guardian): _____

Date: _____

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Financial Policy for Columbus Therapy Associates

Client's Name: _____ Date of Birth: _____

Non-Insurance / Fee for Service: Fee-for-service is exclusively a non-insurance financial arrangement. The fee-for-service arrangement is exclusively separate from the insurance policy scenarios. Fee-for-service receipts cannot be submitted to insurance for reimbursement. If you are engaged in this type of agreement with CTA, full payment must be received for the services rendered at the time of service or upon receipt of invoice from CTA. ☐ (initial)

Attendance Policy: At CTA we understand that sometimes you'll need to cancel due to illness, vacation, other commitments, family visiting, or other reasons. We may need to cancel as well, from time-to-time. We will work cooperatively with you to in order to accommodate make-up sessions, as appropriate. An attendance rate of 80% or above is expected of all scheduled treatment sessions over a 3-month period. Therapist cancellations do not count against the attendance rate. If the attendance rate falls below 80% over this period future visits from that point forward may be canceled. ☐ (initial)

Cancellation Policy: If a visit must be canceled your appointment with CTA, please contact our office at least 24 hours in advance. Courteous notice in advance allows us to better meet the needs of all of our clients. ☐ (initial)

No Show Policy: If you do not show for an appointment and did not call to cancel this appointment in advance, we will charge you $25 for this missed appointment. Please give notice when you are unable to make a scheduled appointment. If you miss 3 consecutive appointments without notice all further appointments will be canceled by our office. If your funding source pays for missed visit appointments or if your visits are paid by a state managed care plan, you will not be responsible for paying this fee however all missed visits will count against your attendance rate. ☐ (initial)

Therapy Termination Policy: It is the policy of CTA that treatment can be terminated based on no showing for 3 consecutive sessions without contacting CTA, showing for fewer than 80% of treatment sessions over a 3-month period, and/or payments due in excess of 30 days. Treatment may be canceled based on behavioral concerns; however, it is the policy of this office that therapists work cooperatively with families & clients to resolve any issues that may arise. Therapists may request that a behavioral support person attend treatment sessions with the client, as necessary, for the safety of all participants. ☐ (initial)

Insurance Carriers: CTA urges you to review your insurance policy's "Schedule of Benefits". You should call your insurance company with any specific questions related to your policy regarding outpatient speech-language and/or occupational therapy benefits. CTA will bill insurance carriers for you if proper paperwork is provided to us. Any outstanding balances, co-payments, and deductible are your responsibility and are due prior to checking in for your appointments. You are responsible for meeting the deductible (in or out of network) before your insurance will begin to reimburse for the services rendered. If you have secondary insurance you must present it at your initial visit. From time-to-time insurance carriers do not pay for services or pay less than anticipated for care, we will do our best to assist you in receiving payment for these services *Please note that billing your insurance *is not a guarantee of payment*. Since your agreement with your insurance carrier is a private one, it is ultimately your responsibility to determine the reasons for reduced payments or non-payment by them to us, and for full payment of your bill. ***If an insurance carrier has not paid***

within 60 days of billing, fees are due and payable in full from you. Please advise office staff of any address, phone, insurance and/or employment changes to ensure accurate billing.

Medicaid & State Managed Care Plans: Our office is a Medicaid participating provider and we will bill Medicaid for you. CTA agrees to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, co-insurance, co-payment or similar cost-sharing charge. Any outstanding balances, co-payments and deductibles are due prior to your appointments. You are required to present a valid Medicaid or other state managed care card on the 1st of every month & as needed throughout your care.

Minors: A parent or legal guardian must accompany the minor patient at the time of the initial visit. The parent or legal guardian is responsible for full payment as outlined in the above financial policy. If the parents are separated and both legally responsible for the child, you must provide complete information from both parents. The parent or legal guardian that accompanies the minor patient to the clinic will have full responsibility for the payment should any dispute arise.

Disputes: CTA's financial policy is designed to promote due diligence. With your participation, this policy will minimize errors and miscommunication with regard to your insurance or other financial arrangement for payment. We will not become involved in disputes between you and your insurance company regarding, but not limited to, deductibles, co-insurance, co-payments, covered services, pre-authorization, and usual & customary charges.

Method of Payments: Our office accepts the following payment methods: Cash, personal check, & credit cards (Visa, Discover, American Express, and Mastercard). For returned checks we assess a charge to you, based on the rate charged to us by our bank. If you have insurance, balances will be considered current from the date your insurance pays its portion. After that, there is a 60-day grace period to pay your portion of the services. If not paid accordingly, the client understands that our office reports to an outside collection agency. In the event that your account is turned over for collections the client agrees to pay all additional fees assessed in the collection of the debt. We will work with you to set-up a customized payment plan if necessary, so please ask to speak with a clinical director to discuss available options.

Patient Consent and Assignment of Benefits: I understand that I am financially responsible for all charges for services rendered regardless of litigation or insurance reimbursement. I understand that the parent accompanying a minor for treatment will be responsible for payment. I hereby instruct CTA to bill my insurance company, if I have so provided, for services rendered and said insurance company to make direct payment of medical benefits to Columbus Therapy Associates. I authorize any physician, hospital, school, referring agency or other person who has records pertaining to treatment at CTA to release such records, upon request, to CTA. Furthermore, I authorize CTA to use or release any of my records it may have to third party payers, government agencies, healthcare providers, insurance carriers, or any other organizations that may assist them in meeting my healthcare needs. I may revoke this authorization in writing at any time and such revocation will be effective as of the date the written revocation is received by CTA. ☐ (initial)

I have read, understood and agreed to the above information and by signing below consent to financial responsibilities, release of information, assignment of benefits, and acknowledgment of privacy practices.

Responsible Party Signature (Adult Client or Parent/Legal Guardian): _____

Responsible Party Printed Name (Adult Client or Parent/Legal Guardian): _____

Date: _____