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

Adult Case History

Date: __________________

I. Identifying & Family Information:

Client 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 ___________________________
cell ___________________________
work ___________________________

transportation ________________________________
relationship/name of company: __________________

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 #: ___________________________

Who lives in the home? ____

Spouses Name: ______________________________
Child/Children's Name & Age:

____ ____
____ ____

Do you have any family history of speech-language and or occupational therapy problems? ___ Yes ___ No
Do you have any family/friends or caregivers who can (or do) assist you throughout the day? ___ Yes ___ No
(If yes, please explain) ____

Are there languages other than English spoken in the home? ___ Yes ___ No
If yes, which one/s? _____________________________
Do you speak the language? ____________________ understand the language? ___________________

II. Medical Information:

Describe precautions regarding your care.

Please check if you have 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:

Are you on any medications? If yes, please list what kind and for what.

III. History of Intervention:

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

Type *Eval. Date* *Professional's Name* *Date & Reason/Result of Therapy*

Please describe your speech and language difficulty (i.e. fluency/stuttering, articulation, receptive or expressive language, social skills/pragmatics, augmentative and alternative communication)

Please describe your occupational therapy difficulty or problem (i.e. sensory, motor functions, fine motor, self-help skills, vocational skills)

What do you see as your most difficult problem at home and/or in your place of employment and within the community?

____

____

____

Please describe any difficulties with hearing or vision

____

____

____

Do you wear glasses? ___ Yes ___ No
Do you wear hearing aids? ___ Yes ___ No

IV. Birth History:
Were you born premature or full term? ____
Explain any complications related to prenatal events/delivery:

____

____

V. Child Development:
What is your general impression of overall development?
Slow _____ Normal _____ Advanced ___

What is your general impression of early motor development?
Slow _____ Normal _____ Advanced ___

VI. Educational History:
Choose the highest grade level completed: 1 2 3 4 5 6 7 8 9 10 11 12
Undergraduate: 1 2 3 4 Bachelor's Degree
Graduate: 1 2 3 4 Master's Degree

Have you ever had difficulty with the following areas? (check all that apply)
______ Understanding ______ Reading ______ Speaking ______ Writing
______ Problem Solving ______ Attention ______ Memory ______ Math

List any specialization, vocational training or area of university study

____

____

Do you have a history of learning difficulties, if yes, please explain?

____

____

____

VII. Employment and Work History:

Most recent occupation____

Employer____ How long have you been employed? __________________

Are you still employed? If so, describe your position and job duties:

____

____

Are you currently driving? ___ Yes ___ No

What are your household responsibilities? (check all that apply)

______ Cleaning ______ Laundry ______ Cooking ______ Grocery Shopping

______ Computer Tasks ______ Yard Work

VIII. Feeding, Swallowing and Dietary History:

Are you on a special diet or diabetic diet? (thickened liquids, pureed foods, mechanical soft etc.) ___ Yes ___ No

(If yes, please describe) ____

Do you have any allergies? ___ Yes ___ No

(If yes, please describe) ____

Do you have any difficulties with feeding and/or swallowing? ___ Yes ___ No

(If yes, please describe) ____

If you have swallowing difficulties, have you had a modified barium swallow study and/or an fiberoptic endoscopic evaluation? ___ Yes ___ No

(If yes, please describe) ____

IX. Augmentative Communication Device/System Use:

Do you currently use an augmentative communication device and/or system? (i.e. Accent 1000 from PRC, T-10 from Tobii Dynavox, Big Mac Switch or Jelly Switch): ___ Yes ___ No

If yes, please answer the questions below:

Name of current device or system used: ____

Any additional information you would like to share:

____

____

____

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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.

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***

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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: ______________________________