Collier Language and Literacy Therapy
Corrie Collier, MCD, CCC-SLP, C-SLDI
45 Lafayette Rd. Unit 215 North Hampton, NH 03862
Corrie@CollierLLTherapy.com (978) 225-3327

Case History

Today's Date: _____

Client Name: _____ Nickname if Preferred: _____
Date of Birth: _____ Age: _____ Gender: _____
Address: _____

Questionnaire Completed by: _____ Phone #:_____
Referred By: _____

Parent(s)/Guardian(s):
Name: _____ Name: _____
Phone #: _____ Phone #: _____
Email: _____ Email: _____

Pediatrician Name: _____ Phone #: _____
Address:_____

Please list and describe any other physicians/specialists involved in care:_____
_____
_____

Family Background

Does the child live with both parents? □ Yes □ No

_____

Is the child adopted? □ Yes □ No

_____

Names and ages of any siblings:_____
_____

Are any languages other than English spoken in the home? □ Yes □ No
Describe the child's use/understanding of language(s) other than English: _____
_____

Is there anything additional you would like to share about the family / home environment? _____
_____

Background

Describe the nature of your concerns about the child's development and/or the primary referral reasons: _____
_____
_____
_____

If anyone else in the family has a speech/language disorder, learning disability, or related diagnosis, please describe: _____
_____

Is the child aware of or frustrated by their communication or learning difficulties? _____
_____
_____

Has the child had a previous speech-language, psychological, or other evaluation?
□ Yes □ No
Please list evaluators, dates, and results:_____
_____
_____
_____

What would you like to see done about your child's speech, language, or learning difficulties?_____
_____
_____
_____

What are some of the questions that you would like answered about your child's difficulties? _____
_____
_____

_____

_____

Medical/Developmental History

Were there any complications during pregnancy, labor, or delivery? ☐ Yes ☐ No

Please describe:_____

_____

Did the child reach developmental milestones on time? ☐ Yes ☐ No

Please describe:_____

_____

Does the child have a history of any of the following?

☐ Allergies	☐ Ear infections	☐ Seizures
☐ Asthma	☐ Ear/PE tubes	☐ Sensory issues
☐ Behavior problems	☐ Feeding/Swallowing issues	☐ Sleep problems
☐ Breathing problems	☐ Hearing Loss/Hearing Aids	☐ Tongue/lip tie
☐ Cardiac condition	☐ High fever	☐ Tonsils/adenoids removed
☐ Cleft lip/palate	☐ Hospitalization	☐ Traumatic brain injury
☐ Diabetes	☐ Surgeries	☐ Vision problems

Please describe any checked items: _____

_____

_____

Has the child been diagnosed with any other medical condition? ☐ Yes ☐ No

Please describe: _____

_____

Has the child had a recent hearing screening? ☐ Yes ☐ No

When and by whom? _____

Has the child had a recent vision screening? ☐ Yes ☐ No

When and by whom? _____

Is the child up to date with immunizations?: ☐ Yes ☐ No

Please describe: _____

Does the child currently take any medications? ☐ Yes ☐ No

If so, please list medication name and reason for medication: _____
_____

Describe any other information about the child's current health status: _____
_____
_____
_____

Has the child received any of the following services? If yes, please list the provider's name and last date of service.

☐ Developmental Pediatrician _____
☐ Neurologist _____
☐ Physical Therapist _____
☐ Occupational Therapist _____
☐ Speech-Language Pathologist _____
☐ Behavioral Therapist _____
☐ Psychologist / Psychiatrist _____
☐ Tutor _____
☐ Other: _____

Does the child have any difficulty with the following:

☐ Answering wh- questions
☐ Confusing words that sound alike
☐ Following directions
☐ Hyperactivity
☐ Organization
☐ Producing speech sounds
☐ Memory
☐ Social Skills
☐ Stuttering
☐ Understanding what they hear
☐ Attention
☐ Behavior
☐ Handwriting/fine motor skills
☐ Gross motor coordination
☐ Playing with others
☐ Reading
☐ Rhyming
☐ Spelling
☐ Telling Stories
☐ Word Retrieval
☐ Other difficulties: _____

Please describe any of the above: _____
_____
_____

What percentage of the child's speech do you understand? _____%

How well do people outside of the family understand their speech? _____%

Educational History

What school does the child attend? _____

What is their grade level: _____

Does the student have an IEP? □ Yes □ No

Does the student have a 504 Plan? □ Yes □ No

Does the student have a Behavior Plan? □ Yes □ No

Does the student receive other intervention services? □ Yes □ No

Describe special education/intervention services:_____

_____

_____

Social History

What are the child's strengths? _____

_____

_____

What are the child's weaknesses? _____

_____

_____

What are the child's favorite activities? _____

_____

_____

Does the child participate in any community activities (ex. sports, etc.)? _____

_____

_____

Is there anything else that is important for us to know about the child?

_____

_____

_____

_____

_____

_____

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Consent for Services

☐ I authorize Collier Language and Literacy Therapy to render appropriate evaluation and therapy services to the client 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 Collier Language and Literacy Therapy in writing. In addition, Collier Language and Literacy Therapy may terminate services by notifying me in writing.

☐ I do not give my consent or am withdrawing my consent regarding Collier Language and Literacy Therapy rendering evaluation and therapy services to the client named below.

_____ _____

Print Name of Client Date

_____

Client Date of Birth

_____ _____

Signature of Client or Legal Representative Relationship to Client

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Policies

Attendance Policy

Consistent attendance and participation in therapy is essential for therapeutic success. While I understand that illnesses and emergencies occur, I respectfully request that you avoid frequent cancellations. Please adhere to our following policy regarding providing advance notification for any cancellations.

- **If you are unable to keep an appointment, please provide 24 hours notice by phone, text, or email.**

- Please reschedule therapy sessions if your child has any highly contagious illness or has had a fever, strep throat, unidentified rash, diarrhea, or vomiting in the last 24 hours. If anyone in your household has had any contagious illnesses which may be spread through coming into your home, please reschedule your appointment.

- You will be charged the full amount of the missed session if you cancel with less than 24 hours notice or fail to appear to a scheduled appointment and the appointment cannot be rescheduled. **If the appointment can be rescheduled, the fee will not apply.**

- If you are late or not home at the time of your scheduled appointment, your appointment slot will be held for 10 minutes. If you are late, your session will still end at the regularly scheduled time.

- If you cancel, are late, or fail to appear for an appointment without providing 24 hours advance notice for 3 or more appointments within 30 days, you may lose your scheduled appointment time.

Payment Policy

- Payment is due at the time of service. Payment is accepted as private pay by cash, credit card, or check. Checks should be made payable to: Collier Language and Literacy Therapy

- If payments by the client are returned for any reason, the returned check fee, denied credit card fee, or any other related fees will be added to the amount owed by the client.

I, _____, understand the attendance and payment policies and the risks of not adhering to them.

_____ _____

Print Name of Client Date

_____ _____

Signature of Client or Legal Representative Relationship to Client

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Acknowledgement That You Have Received Our HIPAA Privacy Notice

Please review the attached Notice of Privacy Practices/HIPAA Policy. Collier Language and Literacy Therapy 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
- Evaluation results
- Treatment notes
- Insurance information

We are required by law to give you a copy of our privacy notice (attached). This notice tells you how your health information maybe used and shared.

☐ I acknowledge that I have received a copy of Collier Language and Literacy Therapy's Notice of Privacy Practices/HIPAA Policy 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 Collier Language and Literacy Therapy cannot disclose my health information other than as specified in the notice.

☐ I understand that Collier Language and Literacy Therapy 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 Client Date

_____ _____
Signature of Client or Legal Representative Relationship to Client

Please Note: It is your right to refuse to sign this Acknowledgement.

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Notice of Privacy Practices/HIPAA Policy

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date 4/19/2019

This Notice of Privacy Practices applies to the following organizations.

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Authorization to Exchange, Obtain, or Release Information

Client Name: _____ Date of Birth: _____

I _____ (client or parent/guardian) hereby grant Collier Language and Literacy Therapy permission to communicate with the following person or agency to exchange, obtain, or release information. **This information includes, and is not limited to, medical records, evaluation reports, therapy notes, academic records, counseling information, and other pertinent information used solely for the facilitation of services rendered to the above-named individual.**

Name:_____
Title: _____
Contact Information: _____
_____

Name:_____
Title: _____
Contact Information: _____
_____

Name:_____
Title: _____
Contact Information: _____
_____

☐ **I grant permission to exchange information via written and mailed report, phone call, meeting, email, and/or fax.**

☐ **I understand that unless revoked, this authorization will remain valid until written revocation of this authorization is presented.**

_____ _____
Print Name of Client Date

_____ _____
Signature of Client or Legal Representative Relationship to Client