Columbus Speech & Hearing Center
2424 Double Churches Road
Columbus, Georgia 31909
(706) 324-6112 / (706) 596-8259 fax

PEDIATRIC SPEECH INFORMATION PACKET
DIAGNOSTIC EVALUATION

Cover letter
Driving Directions to CSHC
If you intend to seek insurance reimbursement
Attendance Policy

Patient Intake & Insurance Information
Case History Form

Consent to Treat
Parent verification of IEP/IFSP status (Pediatrics only)
Telehealth Member Consent Form

In order to be able to properly complete, save and resend, please adhere to the following steps:

1. Download and save to your computer 1st
2. Reopen the document and complete form
3. Save and then attach in an email to thjones@cshcga.com
4. *Print your name in signature blocks. Upon arrival at CSHC you will be asked to sign where needed.

In order to have a diagnostic appointment schedule, please either: 1) complete and email these forms to Tina Harris-Jones at thjones@cshcga.com, 2) hand deliver to our office, or 3) mail them back via USPS. Upon receipt, and review, Tina will contact you to schedule an appointment. Thanks in advance for completing these forms, we look forward to seeing you in our office.

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To Parent/Guardian:

Your physician has referred your child to Columbus Speech & Hearing Center for a speech/ language/ swallowing or occupational therapy evaluation.

In order to proceed with scheduling an appointment, please complete the enclosed documents and return them to us as soon as possible. When we receive the completed documents, we will contact you to schedule the evaluation appointment.

Please tell us the best way to contact you (check all that apply):

- Phone – give us the number to call _____
- Text – give us the number to text _____
- EMAIL – give us your email address _____
- Please tell us when it is best to contact you _____

- Text – **Opt in for TEXT reminders to avoid no-show and late fees.**
  - ☐ I have opted in for TEXT reminders to be sent to me
  - ☐ I do not want TEXT reminders

If you have questions about scheduling, contact Tina Harris-Jones at 706-324-6112, extension 204. Feel free to leave Tina a voice message if she is not available.

Please note that once the evaluation appointment is scheduled this time is dedicated just for your child. If you need to cancel or change the appointment, please contact us 48 hours prior to the appointment to avoid a $50.00 rescheduling fee.

We look forward to seeing you soon.

Chris Weik
Front Office Supervisor
cweik@cshcga.com

Enclosed forms for your general information:

1. *This Cover Page*
2. *Driving directions to Columbus Speech & Hearing Center*
3. *If You Intend to Seek Insurance Reimbursement*

Materials to return to Columbus Speech & Hearing Center before an initial visit is scheduled:

1. *Attendance Policy*
2. *Pediatric Patient Intake and Insurance Information*
3. *Case History Form – Pediatric Speech*
4. *Consent to treat*
5. *Parent verification that the child does/does not have a current IEP*
6. *Telehealth Member Consent Form*

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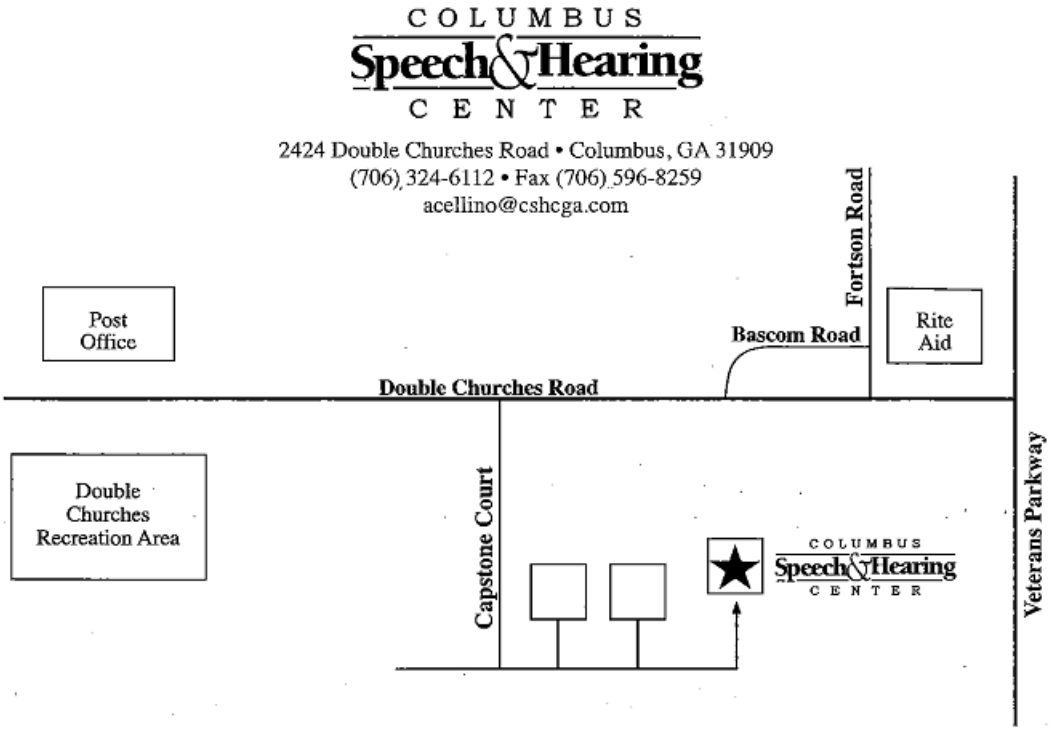
Directions to Columbus Speech & Hearing Center



Coming from LaGrange/Atlanta (I-185 South)

- Take Williams Road, Exit 12
- Turn Left onto Williams Road
- Continue on Williams Rd for almost a mile
- Turn Right onto Fortson Road
- Stay on Fortson until you come to traffic light
- Turn Right onto Double Churches Rd
- Pass Palms Apts on Left; CSHC is next entrance on Left

Coming from Ft Benning (I-185 North)

- Take Exit 10 towards US-27/US-80/GA22/Macon/Phenix City, Al
- Keep Right to GA-22 East/US-80E ramp towards US-27 Macon
- Keep Right to take Veterans Pkwy ramp
- Turn Right on Veterans Parkway
- Cross over I-185; Turn Left onto Double Churches Road
- Pass North Lake Center and Palms Apts; take next entrance to Left to CSHC

Coming from East/Midland (JR Allen/US-80)

- Take Exit 4 towards I-185/Atlanta/Ft Benning
- Keep Right to US-27/GA-1/Veterans Pkwy ramp
- Go through traffic light onto Double Churches Road
- Pass North Lake Center and Palms Apts; take next entrance on Left

Coming from Phenix City (US 80 East)

- Take Exit 4 towards US-27/GA-1/Veterans Pkwy/Moon Road/I-185/Ft Benning/Atlanta
- Stay in Right lane and merge onto Veterans Pkwy/US-27 N/GA-1 toward Hamilton
- Turn Right onto Veterans Parkway
- Turn Left onto Double Churches Road
- Pass North Lake Center and the Palms Apts; take next entrance on the Left

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IF YOU INTEND TO SEEK INSURANCE REIMBURSEMENT

Columbus Speech & Hearing Center is an approved provider for multiple insurance companies. You should know that insurance companies frequently list speech therapy, audiology, and occupational therapy as reimbursable services, but that is not a guarantee of payment, particularly if the disorder is not due to a "medical" condition. Before your first visit, our staff will contact your insurance company and determine if the diagnostic evaluation is covered, if you have related deductible or co-pay. We will share that information with you before your visit here.

Before your first visit, we need:

1. Your physician to send us a prescription for a speech, language, occupation, balance and/or hearing evaluation. These scripts are faxed to our office (Fax: 706-596-8259)
2. A copy of your insurance card, front and back, if that presents a problem you may provide that at your appointment.
3. A completed *Patient Intake and Insurance Information* form, which is enclosed

If therapy is needed and you intend to seek insurance reimbursement:

1. Insurance companies typically require a written Diagnostic Evaluation, which we provide with a request for prior authorization of therapy. We notify you of their response before therapy starts.
2. Insurance companies may require periodic (usually on 6 month intervals) re-evaluations with progress reports. These entail additional reports, updated treatment plans, and staff time. Applicable fees are charged to the patient as "Additional services".
3. In general, we cannot negotiate with your insurance company on your behalf. In case of denials, we will provide any information they request, such as diagnostic reports or daily treatment notes. Will share all knowledge we have of what triggered the denial. If it is due to clerical error on our part, we will correct those errors and resubmit the claim. If it is due to the insurance company's coverage restrictions, we cannot negotiate with them on your behalf.
4. You are ultimately responsible for payment in full for any professional services rendered, regardless of your insurance status. Understand that prior authorization for a procedure is not always a guarantee of payment by the insurance company.

COLUMBUS SPEECH & HEARING CENTER

2424 Double Churches Road / Columbus, Georgia 31909/ 706-324-6112 / FAX 706-596-8259

Welcome! You have taken a major step towards improving you or your child's speech and language by enrolling in therapy. To benefit the most from therapy, you or your child needs consistency, and therefore we require regular therapy attendance. Research has proven that an attendance rate of 87% or more is the best determinant for success. Additionally, based on more than 40 years of experience in this field, when it pertains to pediatric therapy, having fully engaged parents is of great benefit. We welcome and encourage a partnership with you. We want you to observe sessions so you learn how to reinforce new speech patterns at home. We welcome your regular feedback on progress at home. Missed therapy sessions interfere with that progress. Absences also prevent other patients, who can attend regularly, from receiving treatment. Our attendance policies ensure each patient maximizes their individual treatment plan. Please review the following Attendance Policy carefully and notify us if you have any questions about it.

ATTENDANCE POLICY - *Please initial each section*

Initial____ **CANCELLATIONS:** All appointments must be cancelled at least 48 hours in advance by calling or emailing our office, or there will be a cancellation fee charge of $10. This fee is not covered by insurance or other third party payers, and must be paid in full no later than your next appointment. At the time of cancellation, you will be offered make up times within the same week or prior to your next appointment. We will make an effort to reschedule you or your child with the regular therapist, however, make-up therapy sessions may be assigned to an alternate, available therapist. If you reschedule a cancelled appointment and do not attend, you will be charged a cancellation fee for both missed appointments. We will work with you to schedule around vacations, with adequate advance notice (a two week notice of anticipated vacation time is required by CSHC).

Initial____ **NO SHOW WITHOUT NOTICATION:** All appointments missed without notification will be charged $10 for the missed appointment. This fee is not covered by insurance or other third party payer and must be paid in full no later than your next appointment. Patient will not be seen if late cancellation fee has not been paid. Two No Shows in the calendar quarter (e.g. Jan – Mar, Apr-June, July – Sept, Oct – Dec) will result in loss of your future scheduled appointments.

Initial____ **LATENESS:** If you are late to an appointment, we will conclude the session at the usual time. We cannot run over your scheduled time, as this makes the next patient equally late. We are unable to bill insurance for a session if you are late by 15 minutes or more, we WILL NOT be able to see the patient and a cancellation fee will be charged. Please be on time for your session to maximize progress. Also, to keep the office running smoothly, be prepared to exit the therapy room on time.

Initial____ **CLOSING DUE TO WEATHER:** If Columbus Speech & Hearing Center closes due to poor weather, we will contact you (either by phone, text, email, or through Facebook page). We do not necessarily close because school is closed.

Initial____ **HOLIDAYS AND SCHOOL VACATIONS:** Columbus Speech & Hearing Center does not follow the school calendar. We are open 12 months a year and close only for the following holidays: New Year's Day, Memorial Day, July 4th, Labor Day, Thanksgiving Day, Day after Thanksgiving, Christmas Eve, and Christmas Day. Unless otherwise explicitly stated, we are open our regular hours on the days immediately before and after these holidays.

Initial____ **ATTENDANCE:** Therapy will not be effective unless it is consistent and regular. Therefore, regular attendance at all appointments is important. For patients scheduled twice weekly, if four or more appointments within a calendar quarter (e.g. Jan–Mar, Apr-June, July–Sept, Oct–Dec) are missed and not rescheduled, we will remove you or your child from the active therapy list. For patients scheduled once weekly, if two or more appointments within a calendar quarter (e.g. Jan–Mar, Apr-June, July–Sept, Oct–Dec) are missed and not rescheduled, we will remove you or your child from the active therapy list. If your regular appointment time is difficult to maintain, please discuss the possibility of a different time or day with the clinician.

Initial____ **TELETHERAPY:** Teletherapy is the application of telecommunications technology to the delivery of speech language pathology, audiology, and/or Occupational Therapy professional services at a distance by linking clinician to client or clinician to clinician for assessment, intervention, and/or consultation. Columbus Speech & Hearing Center will utilize Teletherapy as medium to provide services when necessary. By initialing, you consent to participate in teletherapy if deemed necessary to provide initial or continued services that you or your child requires.

MY SIGNATURE BELOW INDICATES THAT I HAVE READ THE ABOVE POLICY AND UNDERSTAND AND ACCEPT THE TERMS AND CONDITIONS. I DO HEREBY VERIFY THAT THIS ELECTRONIC SIGNATURE IS AUTHENTIC (WHERE APPLICABLE), AND THE INFORMATION HEREIN IS BEING SUBMITTED BY ME.

s/s_____ _____ _____

PRINT NAME OF PATIENT **PATENT D.O.B.** **SIGNATURE OF PATIENT/RESPONSIBLE PARTY**

DATE _____ **RELATIONSHIP TO PATIENT** _____

CSHC WITNESS _____

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PEDIATRIC PATIENT INTAKE AND INSURANCE INFORMATION

LAST NAME	**FIRST NAME**	**MI**	**BIRTHDATE**

PRIMARY CARE PHYSICIAN	**SSN**	**SEX**

PARENT INFORMATION

MOTHER'S INFORMATION	**FATHER'S INFORMATION**
NAME:	NAME:
ADDRESS:	ADDRESS:
OCCUPATION:	OCCUPATION:
EMPLOYER:	EMPLOYER:
BIRTHDATE: SSN	BIRTHDATE: SSN
HOME PHONE: CELL PHONE: WORK PHONE:	HOME PHONE: CELL PHONE: WORK PHONE:
EMAIL:	EMAIL:

INSURANCE IDENTIFYING INFORMATION

	PRIMARY INSURANCE	**SECONDARY INSURANCE**	**TERTIARY INSURANCE**
NAME OF INSURANCE			
NAME OF POLICY HOLDER			
RELATIONSHIP TO PATIENT			
POLICY NUMBER			
GROUP NUMBER			
PROVIDER CUSTOMER SERVICE NUMBER			
PLAN TYPE: HMO, POS, PPO			

PATIENT VERIFICATION OF ACCURATE INSURANCE INFORMATION AND RESPONSIBILITY FOR PAYMENT

I understand and agree that I am ultimately responsible for payment in full for any professional services rendered, regardless of my insurance status. The information listed above is true and accurate to the best of my knowledge. I understand that all claims are subject to individual contract policy and to medical necessity review. Prior authorization for a procedures is not a guarantee of payment. I will promptly notify you of any changes in my health care coverage or the above information. I do hereby verify that this electronic signature is authentic (where applicable), and the information herein is being submitted by me

_____ _____

*Patient signature or Parent if patient is a minor Date

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CASE HISTORY FORM – PEDIATRIC SPEECH (electronic form)

Patient:	DOB:	CA:	Evaluation date:
Referring physician:	Primary care physician:		
Person completing this form:	Relationship to patient:		
Please describe your concerns about your child's speech/language/swallowing or hearing development:			

Medical History (check all that apply)

Describe any complications during pregnancy or delivery ☐ Toxemia ☐ Maternal diabetes ☐ Premature birth ☐ ☐ Low birth weight ☐ C-section	
Describe any special health, feeding problems, or hospitalizations your child has had:	
How many ear infections has your child had?	Has he/she ever had tubes in the ears? ☐ Yes ☐ No If so when?

Developmental History

Describe any delays in development your child has experienced:		
Describe how well your child plays with other children: ☐ Yes ☐ No Do you have concerns about your child's ability to learn? ☐ Yes ☐ No		
Do you have any concerns about his/her ability to learn? Describe them.		
Who lives in the home?	Number of brothers?	Number of sisters?

Educational History

Where is your child enrolled in school?	Grade level?	How many days a week?
Does your child have any difficulty communicating there? If so, please describe.		
Describe any concerns with attention, behavior, learning or interaction with classmates.		
How does your child's speech or language problem affect him/her academically?		
Is your child currently enrolled in Speech Therapy? ☐ Yes ☐ No	Is there an IEP/IFST? ☐ Yes ☐ No Need Copy	

SPEECH AND LANGUAGE

How does your child express him/herself? ☐ Gestures/signs ☐ Sounds ☐ Words ☐ Sentences ☐ Combination ☐ Other	
How easy is it to understand your child? ☐ Very easy: I understand everything ☐ I occasionally understand ☐ Fair. I must know the topic to understand ☐ Very difficult to understand, even if (s)he repeats ☐ Impossible to understand	
How do you get your child to understand you?	
Describe what you do at home to improve your child's speech/language development	
Have your attempts helped?	How has your child responded to your efforts to help?
Has your child previously been evaluated for speech or language delay? ☐ Yes ☐ No	
Describe any prior therapy and results:	
Who should receive a copy of the report?	

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Patient Name: DOB: Age: Account:

Instructions: Please **initial** beside each of the following items, indicating your authorization or agreement.

Date	Yes, I agree	No, I do not agree	
			CONSENT FOR TREATMENT I hereby consent to such diagnostic procedures, and medical treatment, which in the judgment of my Physicians may be considered necessary or advisable while a patient at Columbus Speech and Hearing Center
			ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Columbus Speech & Hearing Center of the Medical Benefits, otherwise payable to me for services described above, but not to exceed reasonable and customary charges for those services. I understand and acknowledge that this assignment does not relieve me of my financial responsibility. If payment has not been received from the insurance carrier, *I accept personal liability for the charges not reimbursed by Insurance within 45 days.*
			AUTHORIZATION TO RELEASE INFORMATION: I consent to the release of relevant diagnostic, therapy , or other related materials to qualified professional personnel in furtherance of clinical services on behalf of me or my minor being seen; or for whom I am legally responsible, as deemed medically necessary by the attending Speech-Language Pathologist and/or Audiologist at Columbus Speech and Hearing Center.
			ACKNOWLEDGEMENT OF RECEIPT OF *NOTICE OF PRIVACY PRACTICES* (you may refuse to sign this acknowledgement) I have received a copy of this office's *Notice of Privacy Practices.*

_____ _____ _____
Signature Date Witness

MEDICARE OR MEDICAID AS SECONDARY INSURANCE

I am aware that I am personally responsible for any and all Medicare co-pays, co-insurance, and deductibles for Speech and/or Hearing evaluations or therapy. I am aware that Columbus Speech and Hearing Center cannot bill Medicaid for services rendered on patients over 21 years of age. I agree to pay all monies due to Columbus Speech and Hearing Center at the time services are rendered or upon receipt of an invoice for services rendered by Columbus Speech and Hearing Center.

_____ _____ _____ _____
Patient Name Date Parent/Guardian Signature Witness

FOR OFFICE USE ONLY

We have attempted to obtain written acknowledgement of receipt of our *Notice of Privacy Practices*, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

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PARENT VERIFICATION OF IEP STATUS

PATIENT NAME:_____

DATE OF BIRTH: _____

ACCOUNT NO: _____

To whom it may concern:

This letter is to inform you that my child, _____

(Please check one)

☐ Does have a current Individual Education Plan (IEP) or Individual Service Plan (IFSP),

_____ attends school/preschool/daycare at _____

_____

Where he/she receives speech therapy or occupational therapy services.

☐ Does have a current IEP or IFSP, but it does not include speech, language, or occupational therapy services.

☐ Does not have a current Individual Education Plan (IEP) or Individual Service Plan (IFSP). Columbus Speech and Hearing Center is the only provider of speech, language or occupational therapy services for my child.

_____ _____

PARENT OR GUARDIAN SIGNATURE DATE

NOTE: IF YOU CHILD HAS A CURRENT IEP OR IFSP, PLEASE ATTACH A COPY AND RETURN TO COLUMBUS SPEEH & HEARING CENTER.

Thank you for completing these forms, please save them and email our front office manager Chris Weik at cshcga.com. Have a great day!

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Telehealth Member Consent Form

PATIENT NAME: _____

DATE OF BIRTH: _____

INSURANCE/MEMBER ID: _____

1. **PURPOSE:** The purpose of this form is to obtain your consent to participate in a telehealth consultation in connection with one or a combination of the following service(s):

   Speech, Audiology, and/or Occupational Therapy

2. **NATURE OF TELEHEALTH CONSULT:** During the telehealth consultation:
   a. Details of your medical history, examinations, x-rays, and test will be discussed with other health professionals through the use of interactive video, audio, and telecommunication technology.
   b. A physical examination of you may take place.
   c. A non-medical technician may be present in the telehealth studio to aid in the video transmission.
   d. Video, audio and/or photo recordings may be taken of you during the procedure(s) or service(s).
3. **MEDICAL INFORMATION & RECORDS:** All existing laws regarding your access to medical information and copies of your medical records apply to this telehealth consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for this telehealth interaction to researchers or other entities shall not occur without your consent.

4. **CONFIDENTIALITY:** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth consultation, and all existing confidentiality protections under federal and Georgia state law apply to information disclosed during this telehealth consultation.

5. **RIGHTS:** You may withhold or withdraw consent to the telehealth consultation at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

6. **DISPUTES:** You agree that any dispute arriving from the telehealth consult will be resolved in Georgia, and that Georgia law shall apply to all disputes.

7. **RISKS, CONSEQUENCES & BENEFITS:** You have been advised of all the potential risks, consequences, and benefits of telehealth. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telehealth consultation. All your questions have been answered, and you understand the written information provided above.

I agree to participate in a telehealth consultation for the procedure(s) described above.

Signature:_____ Date: _____

If signed by someone other than the patient, indicate relationship: _____

Witness Signature: _____ Date: _____