Wright Pediatric Therapy PLLC
211 E Six Forks Rd STE 107 Raleigh, NC 27609
P: (919) 455-5685 P: (919) 619-2355
Fax: (877) 499-6803

Wright Pediatric Therapy

Case History

Date: _____
Child's Name: _____ Date of Birth: _____
Age: _____ ☐ Male ☐ Female Email: _____
Address: _____
Phone #1:_____ ☐ Cell ☐ Home ☐ Work ☐ Other
Phone #2:_____ ☐ Cell ☐ Home ☐ Work ☐ Other
Pediatrician: _____ Phone:_____
Diagnosis (if known): _____
Is English the primary language spoken in the home: ☐ yes ☐ no
If NO, what is the primary language spoken in the home:_____
How did you hear about Wright Pediatric Therapy? _____

Family Background

Parent(s) Name(s):_____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Who lives at home with the child:_____

Siblings	Age	History of speech disorder
_____	_____	☐ yes ☐ no
_____	_____	☐ yes ☐ no
_____	_____	☐ yes ☐ no
_____	_____	☐ yes ☐ no

Speech Therapy History

Has child had a previous speech, language or feeding evaluation/treatment? ☐ Yes ☐ o
By whom: _____ When: _____

Prenatal/Birth Complications: *Check any items that apply regarding the birth of child:*

During Pregnancy:

☐ Drug Use ☐ Alcohol Use ☐ Smoking ☐ Trauma/Injuries ☐ Significant Illness
☐ High Blood Pressure ☐ Hospitalization

Labor & Delivery:
Birth Weight: _____lbs _____ounces Term: ☐ Full Term ☐ Premature: _____weeks

Type of Delivery: ☐ Normal ☐ Breech ☐ Caesarian ☐ Instrumental

Complications After Birth:
☐ Difficulty Breathing ☐ Difficulty sucking ☐ Difficulty Feeding ☐ Seizures
☐ Jaundice ☐ HIV ☐ Sepsis ☐ Extended Hospital Stay - how long? _____

Medical History

☐ Asthma ☐ Allergies ☐ Brain injury ☐ Cardiac issues ☐ Seizures
☐ Multiple Ear infections ☐ Ear tubes - if YES, when: _____ which ear: _____
☐ Tongue tie ☐ Tonsils/Adenoids Removed ☐ Vision issues ☐ Snoring
Is the child currently on any medications? ☐ Yes ☐ No Which/Frequency? _____
Does the child have any known hearing loss or concern for hearing loss? ☐Yes ☐No
Has your child passed a recent hearing screening? ☐ Yes ☐ No When: _____

Developmental History

At what age (in months) did the child do the following:
Sit alone: _____ Crawl: _____ Stood Up: _____ Walk: _____
Made Sounds: _____ First Word: _____ Combined Words: _____
Sentences: _____ Understood by Others: _____ Fed Self: _____
Toilet Trained: _____ Dressed Self: _____

Does the child do any of the following:
☐ Choke on liquids ☐ Choke on foods ☐ Avoid foods ☐ Maintain a special diet
☐ Use a pacifier ☐ Suck thumb ☐ Mouth objects ☐ Drool excessively
Please describe any of the above: _____

If under 4 years of age, how many words does the child say:
☐ 0-20 ☐ 21-50 ☐ 51-100 ☐ 101-150 ☐ 151-300 ☐ 301-500 ☐ 501+

Does the child spontaneously produce sentences of the following length:
☐ 2 words ☐ 3 words ☐ 4 words ☐ 5+ words

What percentage of the child's speech do you understand? _____%
How well do people outside of the family understand their speech? _____%

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Educational History

Is the child currently enrolled in daycare/ school? ☐ Yes ☐ No

School / Childcare? _____

What day(s) do they attend? _____ What is their grade level: _____

Does your child receive speech therapy in school? ☐ Yes ☐ No Frequency: _____

List any accommodations made for your child in school: _____

CONSENT FOR RELEASE OF CLIENT INFORMATION

I authorize Wright Pediatric Therapy, PLLC to release information in my child's record, including but not limited to evaluation results, care plans, progress notes to:

□ My child's pediatrician:

_____

□ My child's school:

_____

□ My child's CDSA coordinator:

_____

□ Other:

_____

The purpose of any exchange will be to coordinate patient care and collaborate among disciplines.

I understand that this consent is voluntary and that I may revoke this consent in writing at any time.

_____ _____

Patient Name Date of Birth

_____ _____

Parent/Guardian Name Date

Wright Pediatric Therapy

Acknowledgement That You Have Received Our HIPAA Privacy Notice

Wright Pediatric Therapy, PLLC is required by law to keep your health information and records safe.

This information may include:

- Notes from your doctor, teacher or other healthcare provider
- Medical history
- Test results
- Treatment notes
- Insurance information

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

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

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

☐ I understand Wright Pediatric Therapy, PLLC cannot disclose my health information other than as specified in the notice.

☐ I understand that Wright Pediatric Therapy, PLLC 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.

HIPAA Privacy Notice Acknowledgement

_____

Office Use Only

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

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

_____ _____

Staff Member Signature Date

HIPAA POLICY
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

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

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Treatment means providing, coordinating, or managing health care and related services, by one or more health care providers. An example of this would include a physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
The right to inspect and copy your protected health information. The right to amend your protected health information.
The right to obtain a paper copy of this notice from us upon request.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaints with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact the following for more information:

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

Wright Pediatric Therapy

Payment Policy & Fee Schedule

Thank you for choosing our private practice to serve you. We are committed to providing you with the highest quality care. Please know that the timely payment of your bill is an integral part of our service and as such, this payment policy is an agreement between you and Wright Pediatric Therapy for payment of services provided. By signing this policy, you are agreeing to pay for services provided to you or your family member. As a client of Wright Pediatric Therapy you are required to carefully review and sign our payment policy.

Please read the following information carefully:

All therapy fees (including session fees and/or co-pays, if applicable) are due **at the first of each month.**

We accept the following payment methods at this time: credit card payments and checks.

(Checks should be made payable to Wright Pediatric Therapy)

We will provide you with an invoice outlining the services rendered and the amount charged.

Cancellation Policy:

We value the attendance of your child to help Wright Pediatric Therapy grow, as well as your child's communication. As such, we have a cancellation policy of **6 hours** to notify your therapist of any cancellations. A charge of **$25.00** will be deemed at our discretion if Wright Pediatric Therapy is not informed within this **6-hour** window (not applicable to Medicaid and/or CDSA clients), and the session will be considered a "**no show**". This charge will not be covered by insurance and will be an out-of-pocket expense.

Additionally, if your child misses more than **20%** of his/her scheduled sessions, your child may be discharged from therapy at the discretion of Wright Pediatric Therapy.

Name of Client: _____

Please read and check all boxes to acknowledge understanding and the sign below:

☐ I understand that I am responsible for all costs / fees that any third-party payer (ex. insurance company, private school, etc.) does not cover. In the event that a third-party payer source determines that rendered therapy services are “not covered” or otherwise denied, I will be responsible for all outstanding charges. I understand that I will be billed accordingly and will be responsible for immediate payment. I also understand that Wright Pediatric Therapy will not become involved in disputes between you and your third-party source regarding uncovered charges or reasons for denial.

☐ I understand that if fees are not paid in full, treatment sessions may be postponed or canceled until payment is received.

☐ I understand that all returned checks will be subject to a $25 returned check fee. Charges incurred and not paid after 60 days may be turned over to a collection agency at the client’s expense. Overdue accounts may also be reported to a Credit Bureau.

☐ I understand that I am responsible for all legal and collection fees, which Wright Pediatric Therapy may incur if payment is not made in accordance with the terms and conditions herein.

☐ I understand that refunds will be issued only in instances of overpayment. All refunds will be processed within 7 days after the overpayment is discovered on the client’s bill or at the time the refund is requested. Refunds for payments made with a credit card will be credited back to the credit card used, all other refunds will be issued by a check. Client’s who used a third-party source will not be issued a refund until full payment is received from the appropriate source.

☐ I, understand that all cancellations require 6 hours notice and that there will be a $25 charge for any cancellations made less than 6 hours. This charge is my sole responsibility and will not be covered by a third-party source.

☐ I, _____, (client / guardian name) understand the payment policy and the risks of not adhering to it.

_____ _____

Print Name of Client Date of Birth

_____ _____

Signature of Client, Guardian or Responsible Party Relationship to Client

_____ _____

Private Practitioner / Witness Date

Wright Pediatric Therapy
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Lanae@wrightpediatrictherapy.com (919) 619-2355
Danielle@wrightpediatrictherapy.com (919) 455-5685

Health Insurance Verification Form

Patient Name:_____ Subscriber DOB:_____
Primary Insurance:_____ Phone Number: _____
☐ In Network ☐ Out of Network
Member Name:_____ Employer:_____
Member ID #:_____Group Number#: _____
Effective Date:___/___/_____
Is pre-authorization required? ☐ Yes ☐ No
Co-Pay Amount: $_____
Deductible: Individual: $_____Family: $_____Out of Pocket Max: $_____
Progress Towards Deductible to Date: $_____
Number of visits allowed:_____Coverage for therapy services:_____

Additional details / documents needed:_____
_____

Secondary Insurance (if applicable):_____ Phone Number:_____
☐ In Network ☐ Out of Network
Member Name:_____ Employer:_____
Member ID #:_____ Group Number#:_____
Effective Date:___/___/_____
Is pre-authorization required? ☐ Yes ☐ No
Co-Pay Amount: $_____
Deductible: Individual: $_____Family: $_____Out of Pocket Max: $_____
Progress Towards Deductible to Date: $_____
Number of visits allowed:_____Coverage for therapy services:_____

Additional details / documents needed:_____
_____

Insurance Company Spoken With: ☐Primary Insurance ☐Secondary Insurance
Authorization Number:_____
Call Reference Number:_____
Date and Time of Call:_____
Person Spoke With:_____