University of North Texas Speech and Hearing Center
Child Speech-Language Case History

Date ________________

Child's name __________________________ Birthdate ______________ Sex ______________
Address _____________________________ Home phone (____) ________________________
City ________________________ State _______________ Zip __________________________
Father's name ________________________ Mother's name ____________________________
Address _____________________________ Address __________________________________
City ___________ State _____ Zip _______ City___________ State _____ Zip_____________
Father's occupation ___________________ Mother's occupation ________________________
Father's employer ____________________ Mother's employer __________________________
Business telephone (____)______________ Business telephone __________________________
Father's age ____ Education ____________ Mother's age ____ Education _________________
Referred by: ____
(name) (relationship)
Address: ______________________________ Phone Number___________________________

Please describe your concerns regarding your child's communication.
____

____

____

Has your child ever been evaluated or treated for a speech/language problem? Y / N

If so, when? ____________________________ Where? __________________________

Please describe results of the evaluation/treatment ________________________________

____

____

____

Please list any specific questions you would like answered about your child's communication.
____

____

____

Medical History – Please tell us about your child's health history

Please check any of the following that apply to your child:

_____Complications during pregnancy/delivery
_____Extended hospitalization at birth
_____Feeding problems/difficulty gaining weight
_____Serious illness/hospitalization
_____Ear infections/PE tubes
_____Seizures
_____Respiratory problems
_____Allergies
_____Asthma
_____Physical disability
_____History of brain injury
_____Other illnesses requiring medical treatment for 3 months or longer
(Describe____)
Please describe your child's current health ______good _____fair_____poor.

Has your child ever been tested for or diagnosed with any of the following:

____ ADD, ADHD
____ Auditory Processing Disorder (APD)
____ Syndrome (Down's)
____ Cranial Facial Abnormalities
____ Autism
____ Specific Language Impairment
____ Mental Retardation

Has your child had a hearing evaluation? _____yes ____no__________________When?
Results:____________________________
Does your child have hearing problems? ______yes ______no _____unsure
Does your child have vision problems? _______yes ______no ______unsure
Is your child on and medications? ____ yes _____no
Medications:____
____
____
Reason Prescribed: ____
____
____

Growth and Development – Please tell us about your child's development

Please tell us at what approximate age your child did the following (if your child currently does not have this skill, please respond *does not do*)

Sit alone______________________________
Crawl________________________________
Walk alone____________________________
Gain bladder control______________________

Gain bowel control_________________________
Follow a simple command ("Wave bye bye")_____________
Say first words ___________________________
Combine 2 or more words________________________________
Drink independently from a cup___________________________

Please check any of the following that you feel describe your child:
_______Does not use words/sentences as well as other children his/her age
_______Can not be understood as well as other children his/her age
_______Does not appear to listen and understand as well as other children his/her age
_______Does not appear interested in communicating with others
_______Does not communicate as well as he/she did at an earlier time
_______Appears frustrated by communication problems
_______Does not initiate communication with parents or familiar people
_______Has difficulty controlling his/her temper
_______Has difficulty controlling his/her behavior

Family/Social History – Please tell us about your child's family/social environment

Please list family members that the child lives with:

Name Age Relationship

____
____
____
____
____

Other important family members who do not live in the household:
____
____
____

Does anyone in the immediate family (siblings, parents) have speech, language or hearing problems?______Yes ___________No
What language(s) is/are spoken in the home?_____________________________________
Does child attend a preschool or childcare program? ____Yes ____No ___________How Long?

Has child ever received Early Childhood Intervention (ECI) services?_____Yes___No
Please describe child's social/play opportunities

Please describe things your child enjoys doing or playing with:

____

____

____

Other Information – Please provide any additional information you feel is relevant

____

____

____

Educational History – Please complete if your child is school-age

Education placement _______Public school _______Private school _____Home school
Name of School:____________________________________ Grade:___________
How would you describe your child's school achievement? _______Excellent _______Good
________Requires lots of effort ________Has trouble even with help
Do you have any concerns about your child's success in school?_______Yes ______No
Do you think your child's communication may limit success at school?_____Yes___No
Has your child been evaluated or received speech therapy at school?____Yes ____ No
Has your child ever been tested for special education?________Yes ________No
Does your child receive any special education services?_______Yes _______No
Please describe your child's grades______________________________________
What subjects/classes are easiest for your child?____________________________
What subjects/classes are most difficult for your child?_______________________
Please check any of the following that you believe apply to your child:
______Difficulty learning to read
______Difficulty learning to write
______Difficulty following instructions/routines in class
______Attention problems in school
______Behavior problems in school
______Difficulty passing standardized tests (TEKS, etc)
______Requires longer time to complete assignments than other children
______Seems to struggle with work more than other children
______Dislikes School

Please describe any concerns you have regarding your child's educational achievement:

____

____

____

____

Medical Insurance Information

Primary Insurance:

/ /

Name of insurance company / Insurance Company Street Address / City, State, Zip Code

/ /

Insurance company phone number / Identification Number / Policy or Group number

Policyholder name ______ Policyholder: Male: ______ Female ______ Policyholder's date of birth ______

Patient's relationship to policyholder: Self: ______ Spouse: ______ Child: ______ Other: ______

Secondary Insurance:

/ /

Name of insurance company / Insurance Company Street Address / City, State, Zip Code

/ /

Insurance company phone number / Identification Number / Policy or Group number

Policyholder name ______ Policyholder: Male: ______ Female ______ Policyholder's date of birth ______

Patient's relationship to policyholder: Self: ______ Spouse: ______ Child: ______ Other: ______

Tertiary Insurance:

/ /

Name of insurance company / Insurance Company Street Address / City, State, Zip Code

/ /

Insurance company phone number / Identification Number / Policy or Group number

Policyholder name ______ Policyholder: Male: ______ Female ______ Policyholder's date of birth ______

Patient's relationship to policyholder: Self: ______ Spouse: ______ Child: ______ Other: ______

Billing Information
Insurance Release Form

Patient Information:

/ /
Last name First name Middle

/ / / /
Street Address Apt/Lot # City State Zip Code Home Phone #

/
Social Security # Date of Birth Male ______ Female ______ Student: Full-time ______ Part-time ______

Single Married Divorced Separated Widowed Employed Retired

/ / ( )
Physician City Phone number

Responsible Party:

/ /
Full Name Social Security number Date of Birth

/ / / /
Street Address Apt/Lot # City State Zip Code Home Phone #

/
Employer Position

/ / / /
Employment street Address Apt/Lot # City State Zip Code Work Phone #

/ /
Spouse's full name Social Security number Date of birth

/ / / /
Street Address Apt/Lot # City State Zip Code Home Phone #

/
Employer Position

/ / / /
Employment street Address Apt/Lot # City State Zip Code Work Phone #

/ /
Nearest relative or friend/Emergency contact Relationship to patient Phone number

Private Insurance and Medicare/Medicaid Authorization

I authorize payment of medical/Medicare/Medicaid benefits to University of North Texas Speech and Hearing Center for any services furnishe to me by the licensed professionals in the clinic. I also authorize you to release to my insurance company or Medicare/Medicaid Administrator any information concerning my health care, advice, treatment, or suplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Date ______________________ Signature ______________________

I understand that I am responsible for payment of all charges incurred on behalf of myself and my family regardless of insurance benefits.

Date ______________ Responsible Party ______________________

University of North Texas

Speech and Hearing Center

Authorization

Client Name: _________________________________

The University of North Texas Speech and Hearing Center is a training facility designed to provide speech-language pathology and audiology student clinicians with clinical experience. Student clinicians are involved in all aspects of client service delivery. All clinical services are provided under the guidance/supervision of clinical supervisors who hold current state licensure and national certification in Speech-Language Pathology or Audiology. Additionally, student observers may be assigned to observe evaluation/treatment sessions conducted in the center. At times, videotapes of evaluation/therapy sessions are made to assist student clinicians/supervisors in evaluating and planning therapy activities. These videotapes are viewed only by students/clinicians of the Center involved in the case.

_____ I hereby authorize the University of North Texas Speech and Hearing Center to render Speech-Language Pathology/Audiology services to me.

_____ I hereby authorize students of the Department of Speech and Hearing Sciences to observe evaluation/treatment sessions.

_____ I hereby authorize videotaping of sessions for use by the student/supervisor assigned to me.

Signature: ____________________________________

Date: ____

University of North Texas

Speech and Hearing Center

Authorization to Release
Protected Health Information

I hereby authorize the University of North Texas Speech and Hearing Center to release my protected health information to:

____
Agency/Individual Name

____
Address

____
Phone Number

____
Fax Number

For the purpose of:

____

____

____

I authorize release of the following:

____

____

I understand that I may revoke this authorization by submitting a written request to the Center. Such a revocation does not apply to releases prior to the date of the request.

______________________________ ____________________
Client or Legal Guardian Date

For Internal Purposes Only:

University of North Texas
Speech and Hearing Center

Information Regarding Protected Health Information

I have read the Notice of Health Information Practices provided by the University of North Texas Speech and Hearing Center. I understand how the Center will utilize my protected health information (PHI) and my rights regarding my protected health information.

____________________________	________________________
Client or Parent/Guardian	Date

University of North Texas Speech and Hearing Center

Notice of Health Information Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

The UNT Speech and Hearing Center is committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit the UNT Speech and Hearing Center, a record of your visit is made. Typically, this record contains documentation of treatment you received and recommendations for future treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the other health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided

How Your Protected Health Information (PHI) is Used or Disclosed

The following information describes how we may use your PHI without your written consent. Your PHI will be used by the UNT Speech and Hearing Center for treatment, payment, or healthcare operations (TPO). Some specific examples include:

> Treatment – Your PHI may be shared with other Health Care professionals in order to provide you the best care. These Health Care professionals may be other clinicians within the UNT Speech and Hearing Center or other providers outside of the Center who are involved in your treatment.
>
> Payment – Your PHI may be shared with billing personnel in order to assure that you are properly charged for services provided. PHI may also be shared with your medical insurance plan administrators to assure payment of a claim.

Health Care Operations – Your PHI may be shared with the UNT Speech and Hearing Center personnel to schedule appointments, order hearing aides, and for quality assurance/improvement efforts. Your PHI may be disclosed to others outside the Center as required by state or federal laws.

The Center may also disclose PHI:

- In order to contact you regarding appointments
- For activities related to supervision of student clinicians involved in your care
- To you, the patient, or if the patient is a minor, to the legal guardian
- To others involved in your care – such as family members
- For law enforcement purposes
- To correctional institutions
- For national security or intelligence
- For fund raising activities for the Speech and Hearing Center, or for UNT

Release of Protected Health Information (PHI)

Except for the situations described above, you must sign an authorization to release your PHI. This authorization will specify who the information will be released to and for what purpose. The Speech and Hearing Center will maintain records of authorized release of your PHI. You may request an accounting of those releases in writing, and you may receive one copy of the accounting detailing all release over the past 12 month period (subsequent to April 14, 2003) free of charge. You may also request specific restrictions for release of your PHI although the center is not required to agree to all requested restrictions. You may revoke an authorization by submitting a written request to the center; however, such a revocation is only valid from the date of the written request and does not include releases prior to that date.

Your Rights to Access/Amend Your PHI

You have the right to inspect and copy your PHI. Requests for inspection must be submitted to the Center in writing, and the Center must respond within 15 days or request a 30-day extension with cause for extension stated. Request to change or amend PHI must be made in writing. Such requests may be denied by the Center.

Responsibilities of the Speech and Hearing Center Regarding Your PHI

The Speech and Hearing Center is required to:

- Maintain the privacy of your health information
- Provide you with this notice of our legal duties and privacy practices regarding your health information
- Allow you access to your health information
- Notify you if we are unable to agree to a restriction regarding release of your information

The Speech and Hearing Center is required by law to provide public notice that assures privacy of PHI is maintained. The Center is required to provide clients with notice of the Center's privacy practices for PHI. The Center may make changes to the privacy practices; however, those changes must be described in an updated Privacy Notice before changes are implemented. The updated Privacy Notice will be available to patients upon request.

Your Rights to Report a Complaint or Problem

You have the right to report a complaint if you believe your privacy rights have been violated. The complaint should be submitted in writing and should specify how the privacy policies were violated. The complaint must be filed within 180 days of the act or omission. The complainant will not be subject to any retaliation for filing a complaint.

To obtain further information on the UNT Speech and Hearing Center policies regarding Protected Health Information
Or

To file a complaint regarding Protected Health Information contact:

Kathy Thomas
Director, Speech and Hearing Center
PO Box 305010
Denton, TX 76203-5010
940-369-7339
kathyt@unt.edu

The UNT Speech and Hearing Center welcomes the opportunity to serve a diverse clientele. We do not discriminate with regard to gender, sexual orientation, age, race, creed, national origin or, disability.