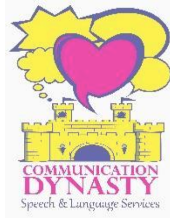
Communication Dynasty LLC
1101 Belleview Street
Columbia S.C. 29201

Fax: 803 470-3639 Phone:803 667-9443



Email: communicationdynasty@gmail.com

SPEECH AND LANGUAGE CASE HISTORY

Childs Name: _________________________ Date of Birth: ________________

Address: ______________________________ Phone Number: ______________________________

Guardians Name: _______________________________ Email Address: ________________________

Pediatrician: _________________________ Insurance Information: ______________________________

Describe the child's current speech/language problem:

____
____
____

_____ Age of first spoken word _____Age of first spoken sentences

Describe the child's communication at the present time. (Please check all that apply.)

__ Grunts and Points __ Copies What You Say __ Stutters

__ Screams __ Single Words __ Too Soft

__ Gestures __Two-Word Phrases __ Too Loud

__Takes You To Object __Longer Sentences __ Hoarse

__Copies What You Do __Unclear Speech

Indicate any family history of speech or language problems:

____
____
____
____

School/Daycare: ______________________________________ Grade: ________________

Has the child received previous speech/language therapy? ___YES ___NO

Is the child currently receiving speech/language services? ___YES ___NO

Comments about School:

____

____ DEVELOPMENT

At what age did the following first occur?

________ Sat Up Alone _________ Crawled

________ Walked Unaided _________ Gained Bladder Control

Does the child appear clumsy or awkward? ____YES ____NO

Has the child received any intervention or therapy for motor development? ___YES ___NO

PRENATAL/BIRTH HISTORY (Questions apply to the birth of this child.)

Mother's illnesses, accidents or infections during pregnancy:

____

____

Which of the following did the mother experience during pregnancy?

___X-rays ___Drug/Alcohol Problems ___Measles

___Medication ___Surgery ___Accidental Injury

___Chicken Pox ___Toxemia

Length of Pregnancy________________________

Length of Labor ____________________________

Any complications at delivery?

____

____

Did the child experience any of the following conditions immediately following birth?

___Breathing Difficulties ___Oxygen Needed ___Feeding Problems

___Jaundice ___Seizures ___Sucking/Swallowing

___Bleeding ___Infections Problems

Were there any other abnormalities or conditions not already mentioned?

____
____

MEDICAL

Please check all that apply

___High Fever ___Other Injuries ___Eating/Swallowing

___Ear Infections ___Hospitalizations Problems

___Seizures ___Illnesses ___Wears Glasses

___Asthma ___Operations ___Hearing Problems

___Frequent Colds ___Medications ___Wears a Hearing Aid

___Allergies ___Diagnosed with ___Behavioral Problem

___Head Injuries ADHD/ADD

Please explain the items checked:

____
____

Describe any physical disability or condition:

____
____

Is the child currently taking any medications? If so, please list:

____
____

FAMILY INFORMATION

Father's Name: _______________________________

Mother's Name: ________________________________

Parents Phone Number: __________________________

Others Living in Child's Home:

Name:________________________________Age:_____Relationship:_____________________
____

Name:________________________________Age:_____Relationship:_____________________
____

Name:________________________________Age:_____Relationship:_____________________
____

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Permission to Evaluate/ Treat

I________________________________, herby consent to the evaluation, treatment, and insurance billing for my child,________________________________. The assessment may include: observation of the child; formal and informal testing; follow up visits; and ongoing intervention. I understand that the results of the Assessment and the Plan of Care will be discussed with me. I agree to comply with the Plan of Care with the best of my ability for the best outcome for my child. I understand that at any given time I have the right to refuse care and revoke my consent for treatment with Communication Dynasty LLC.

Communication Dynasty Speech Therapy, LLC deem it their responsibility to provide effective and quality treatments to their families in a safe environment. If a therapist feels that a situation is unsafe for them personally, Communication Dynasty Speech LLC, reserves the right to discontinue services.

Communication Dynasty Speech Therapy, LLC has an obligation and responsibility to their professional guidelines and standards of practice. Therefore, when a child no longer qualifies for services or therapy is no longer effective or productive for various reasons, a discharge summary will be completed with or without an FMP (Functional Maintenance Plan) in place for your child depending on circumstances. It is the right of the caregiver at any time for any reason to request a change in providers.

SESSION PARTICIPATION AND CANCELLATION POLICY CONSENT:

________ I agree to actively participate in the scheduling of my child's session and understand that 3 unscheduled absences may result in discharge from therapy services. In addition, I agree to be available to assist my child's therapist regarding sessions; in the compliance with the plan of care; and following the home exercise program under the direction of my child's therapist.

INSURANCE AND PAYMENT POLICY CONSENT:

_________I authorize Therapy Consortium, LLC, on behalf of Communication Dynasty LLC, to submit claims to my insurance company on my behalf and authorize my insurance company to pay benefits as well as release the explanation of benefits to Therapy Consortium, Inc. In the event that a therapy service is not covered by my private insurance and no additional insurance is active such as Medicaid, or Babynet, I agree to pay, Communication Dynasty Speech LLC, the current rate of $120 for evaluations and $100 for treatment sessions within 30 days of service. I understand that I will not be billed for any Medicaid "covered" services furnished to me which were billed to Medicaid during the time I had active Medicaid Coverage for those services.

________ I understand that I must notify Communication Dynasty Speech Therapy, LLC immediately should there be a change in insurance.

RELEASE OF INFORMATION CONSENT:

______ I authorize, Communication Dynasty Speech Therapy, LLC, to release information to health professionals involved with your child to include: case management providers; Babynet representatives; and insurance companies for processing all medical claims on the patient's behalf through written or verbal communication, via regular mail, electronically or by fax. I agree to receive clinical reports from Communication Dynasty Speech LLC, through encrypted email in order to protect its content.

MULTI MEDIA CONSENT:

______ I hereby give my consent for use of photo(s) and video(s) of my child during therapy for presentations, education, research purposes, and social media story telling (such as

Facebook/Website/Instagram/YouTube) to Communication Dynasty Speech Therapy, LLC. I understand that at any time I can revoke my consent for all use or use of a particular item.

______I decline to give consent for use of photo(s) and video(s) of my child during therapy. I understand that declining will not impact the quality of speech therapy services that my child receives.

ACKNOWLEDGMENT THAT YOU HAVE RECEIVED OUR HIPAA PRIVACY NOTICE:

______ Communication Dynasty Speech Therapy, LLC, along with Therapy Consortium Inc, are required by law to keep your health information safe. This information may include documents to and from: your doctor(s); school(s); or other healthcare provider(s). Examples of this health information may include: medical history(s); test results; therapy notes; and insurance information. We are required by law to give you a copy of our HIPPA privacy notice which provides you more details on how your health information may be used and shared.

Signature of Parent/ Guardian_____________________________________

Date: __________________________

Staff Signature_____________________ **Date:** _________________________