Cornerstone
BEHAVIORAL HEALTH
PEDIATRIC THERAPIES

Consent to Screen, Evaluate And/Or Treat For Speech Therapy

Patient Name: _____ Date of Birth: _____

Address: _____

Patient's Doctor: _____ Phone # of Doctor: _____

Insurance Information

Primary Insurance: _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Number: _____ Group Number: _____

Phone Number:_____

Secondary Insurance: _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Number: _____ Group Number: _____

Phone Number:_____

Does your child currently receive: ☐ IFSP/Sooner Start ☐ IEP ☐ WIC

I authorize Cornerstone Behavioral Health and Pediatric Therapies, Inc. to screen, evaluate, and provide any subsequent treatment needed based on the evaluation results for Speech Therapy for the above named child.

Parent Signature: _____ Date:_____

Printed Name: _____ Date: _____

Relationship to Patient : ☐ Parent ☐ Legal Guardian ☐ Other: _____

Signature of Speech Therapist:_____ Date:_____

Printed Name:_____ Date:_____

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Case History Form

Child's Name: _____ Birthdate: ____/____/_____ Sex: ☐ M ☐ F

Father's Name: _____ Daytime Phone: _____

Address: _____

Cell Phone: _____

E-mail: _____

Mother's Name: _____ Daytime Phone: _____

Address (if different): _____

Cell Phone: _____

E-mail: _____

Doctor's Name: _____ Doctor's Phone: _____

Child lives with (check one)**:**

☐ Birth Parents ☐ Adoptive Parents ☐ Foster Parents

☐ Parent and Step-Parent ☐ One Parent ☐ Other _____

Other children in the family:

Name	Age	Sex	Grade	Speech/Hearing or Learning Problems

___

Child's race/ethnic group:

☐ Caucasian, Non-Hispanic ☐ Hispanic ☐ Native American

☐ Asian or Pacific Islander ☐ African-American ☐ Other_____

Is there a language other than English spoken in the home? ☐ Yes ☐ No

If yes, which one?_____ Does the child speak the language? ☐ Yes ☐ No

Does the child understand the language? ☐ Yes ☐ No

Who speaks the language?_____ Which language does the child prefer to speak at home? _____

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Speech-Language-Hearing History

Do you feel your child has a speech problem? ☐ Yes ☐ No

If yes, please describe.

_____

_____

Do you feel your child has a hearing problem? ☐ Yes ☐ No

If yes, please describe.

_____

_____

_____

___

Has he/she ever had a speech evaluation/screening? ☐ Yes ☐ No

If yes, where and when? _____

What were the results? _____

Has he/she ever had a hearing evaluation/screening? ☐ Yes ☐ No

If yes, where and when? _____

What were the result?_____

Has your child ever had speech therapy? ☐ Yes ☐ No

If yes, where and when? _____

What was he/she working on? _____

Has your child received any other evaluation or therapy (physical therapy, counseling, occupational therapy, vision, etc.)? ☐ Yes ☐ No

If yes, please describe._____

_____

Is your child aware of, or frustrated by, any speech/language difficulties?_____

What do you see as your child's most difficult problem in the home?

_____

What do you see as your child's most difficult problem in

school?_____

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Birth History

Was there anything unusual about the pregnancy or birth? ☐ Yes ☐ No

If yes, please describe.

_____

_____

__

How old was the mother when the child was born? _____

Was the mother sick during the pregnancy? ☐ Yes ☐ No

If yes, please describe.

_____

How many months was the pregnancy? _____

Did the child go home with his/her mother from the hospital? ☐ Yes ☐ No

If child stayed at the hospital, please describe why and how long.

_____

Medical History

Has your child had any of the following?

☐ adenoidectomy	☐ allergies	☐ breathing difficulties
☐ chicken pox	☐ colds	☐ ear infections
☐ ear tubes	☐ encephalitis	☐ tonsillitis
☐ flu	☐ head injury	☐ high fevers
☐ measles	☐ meningitis	☐ mumps
☐ scarlet fever	☐ seizures	☐ sinusitis
☐ sleeping difficulties	☐ tonsillectomy	☐ vision problems

☐ thumb/finger sucking habit

Other serious injury/surgery: _____

Is your child currently (or recently) under a physician's care? ☐ Yes ☐ No

If yes, why?_____

Please list any medications your child takes regularly:

_____

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Developmental History

Please tell the approximate age your child achieved the following developmental milestones:

_____ sat alone

_____ babbled

_____put two words together

_____walked

_____grasped crayon/pencil

_____ said first words

_____spoke in short sentences

_____ toilet trained

Does your child...

☐ choke on food or liquids?

☐ currently put toys/objects in his/her mouth?

☐ brush his/her teeth and/or allow brushing?

Current Speech-Language-Hearing

Does your child...

☐ repeat sounds, words or phrases over and over?

☐ understand what you are saying?

☐ retrieve/point to common objects upon request (ball, cup, shoe)?

☐ follow simple directions ("Shut the door" or "Get your shoes")?

☐ respond correctly to yes/no questions?

☐ respond correctly to who/what/where/when/why questions?

Your child currently communicates using...

☐ body language.

☐ sounds (vowels, grunting).

☐ words (shoe, doggy, up).

☐ 2 to 4 word sentences.

☐ sentences longer than four words.

☐ other _____

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Behavioral Characteristics:

☐ cooperative	☐ attentive	☐ willing to try new activities
☐ separation difficulties	☐ restless	☐ plays alone for reasonable length of time
☐ destructive/aggressive	☐ stubborn	☐ easily frustrated/impulsive
☐ self-abusive behavior	☐ poor eye contact	☐ easily distracted/short attention
☐ withdrawn	☐ inappropriate behavior	☐ easily frustrated/impulsive

School History

If your child is in school, please answer the following:

Name of school and grade in school:

Teacher's name:

Has your child repeated a grade?

What are your child's strengths and/or best subjects?

Is your child having difficulty with any subjects?

Is your child receiving help in any subjects?

Additional Comments

_____

_____

_____

_____

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Patient Attendance Policy

Cancelation Fee not Applicable to those with Soonercare Insurance. In order for us to ensure the best possible results from therapy, you must actively participate in the program developed for you by attending all scheduled sessions. Please be respectful to your therapist and to other patients who are waiting to be scheduled by adhering to the following:

Sick Policy: If your child has had a fever (99 degrees or above), nausea, vomiting, or diarrhea in the past 24 hours, do not bring them to therapy. Call and let the office know. In order to resume therapy, your child must be fever and symptom free for 24 hours.

Appointment Cancellation Policy: Call at least 24 hours in advance to cancel or reschedule any appointments. Cancellations under 24 hours are acceptable only due to illness, death in the family, or other significant family emergencies. Frequent cancellations (25% or more of total visits) will result in a $25.00 fee for future missed visits. We try to offer appointment times that are most convenient for your busy schedule. If you need to reschedule your appointment with short notice, please understand that you may need to see another therapist, accept a less than optimal appointment time, or wait until the next scheduled opening becomes available.

Appointment No Show Policy: Our therapists have set aside a specific time to provide your therapy. When you do not call to cancel or do not show for your appointment, this is time the therapist could be providing therapy to someone else. We understand emergencies do arise requiring schedule changes, however, we do expect a call. After three missed appointments with no notification, you will lose your scheduled appointment time. You will receive one phone call notifying you and then it will be up to you to reschedule. Once rescheduled, any future missed appointments without a 24-hour advanced notification will result in being charged the full therapy amount. This balance on your account will not be covered by insurance and will need to be paid before scheduling any additional appointments.

All cancellations or no shows will be reported to your referring physician and insurance company. We are not responsible for any resultant adverse effects.

**Please be informed that if your insurance requires a prior-authorization for therapy and you only attend a portion of your sessions, your insurance company will likely reduce number of visits in future authorizations or completely deny future requests.*

Acknowledgment I have read the attendance policy and acknowledge my understanding as well as agree to the terms.

_____

Patient Name

_____ _____

Signature of Parent or Guardian Date

Cornerstone Behavioral Health and Pediatric Therapies, Inc.

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.

If you have any questions about this notice please contact Carolyn Donaghey at Cornerstone Behavioral Health and Pediatric Therapies, Inc. at (405) 455-6868 or by email at office@cornerstoneok.org

This Notice of Privacy Practices describes how Cornerstone Behavioral Health and Pediatric Therapies may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Cornerstone Behavioral Health and Pediatric Therapies is required to abide by the terms of this Notice of Privacy Practices. Cornerstone Behavioral Health and Pediatric Therapies may change the terms of this notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

USES AND DISCLOSURES OF HEALTH INFORMATION: Treatment: Information about you may be used by the personnel (including students in the field of speech- language pathology who are completing extern placements) associated with Cornerstone Behavioral Health and Pediatric Therapies for diagnosis, treatment planning, and treatment. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client’s legal guardian or personal representative. It is the policy of Cornerstone Behavioral Health and Pediatric Therapies to release private health information only to clients or the parents/guardians of clients if clients are minors. In some cases, should Cornerstone Behavioral Health and Pediatric Therapies need to send information to another professional, a signed Release of Information form is required.

Payment: Cornerstone Behavioral Health and Pediatric Therapies bills directly to insurance companies. You will be given a Notification of Benefits and Financial Responsibility form. You will be responsible for all services rendered that are not covered by your insurance in addition to any co-payments and/or co-insurance amounts required.

Cornerstone Behavioral Health and Pediatric Therapies will communicate with you only in ways you have provided on the Contact Information form you completed prior to starting therapy. It is the client's responsibility to update contact information with Cornerstone Behavioral Health and Pediatric Therapies.

OTHER DISCLOSURES: Cornerstone Behavioral Health and Pediatric Therapies may use or disclose your protected health information in some situations without your authorization or providing you the opportunity to agree or object. Some of these situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or

disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification

and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected

health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

YOUR RIGHTS:

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. Copies can be obtained for $.25 a page.

Under federal law, however, you may not inspect or copy records related to information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding. Depending on the circumstances, a decision to deny access may be reviewable.

You have the right to revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

You have the right to request that information about you be communicated by other means or to another location.

You have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

COMPLAINTS: If you believe your rights have been violated by Cornerstone Behavioral Health and Pediatric Therapies please bring the problem our attention first. Your concerns will be addressed in a timely manner. If you are not satisfied with the manner in which the Clinical Director, Dr. Gotcher, PhD (ngotcher@cornerstoneok.org or 405-455-6868) handles a complaint, you may submit a formal complaint to:

Attn: Director Office for Civil Rights U.S. Department of Health and Human Services 200 Independence Avenue, S.W. Room 509F HHH Bldg. Washington, D.C. 20201

This notice was published and becomes effective on signed date below. It will remain in effect for two years from this date.

_____ _____

Legal Guardian Signature Date

_____ _____

Cornerstone Representative Signature Date

Cornerstone
BEHAVIORAL HEALTH
PEDIATRIC THERAPIES

Authorization for Release of Information

Patient Name: _____ Date of Birth: ____/____/____

I authorize Cornerstone to release information TO:

1. Name of Provider or Facility:_____

   Address:_____

   Phone #:_____

   Fax #:_____

   Information requested/authorized: ☐Evaluation ☐Records ☐Other: _____
2. Name of Provider or Facility:_____

   Address:_____

   Phone #:_____

   Fax #:_____

   Information requested/authorized: ☐Evaluation ☐Records ☐Other: _____

I authorize Cornerstone to obtain information FROM:

1. Name of Provider or Facility:_____

   Address:_____

   Phone #:_____

   Fax #:_____

   Information requested/authorized: ☐Evaluation ☐Records ☐Other: _____

_____ _____

Signature of Parent or Guardian Date

_____ _____

Cornerstone Representative Date

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Financial Responsibility Statement

Patient Information:

Patient full name: _____

Patient's DOB: ____/____/_____

Patient's sex: M_____ F_____

Patient's relationship to subscriber: Self___ Child_____ Other_____

Subscriber Information:

Name of subscriber: _____

Subscriber DOB: ____/____/_____

Insurance Company: _____

Member ID:_____

Group Number: _____

I authorize the release of any medical or other information necessary to process insurance claims. I further authorize the payment of medical or insurance benefits to Cornerstone Behavioral Pediatrics, and authorize Cornerstone Behavioral Pediatrics to obtain or release therapy records and treatment plans to my insurance company for the purpose of evaluation, treatment and payment.

By signing this form I am stating that I understand and agree to the following:

Fees for services were reviewed with me and agreed upon prior to the commencement of services. Payment is due at the time services are rendered unless other arrangements have been Made. All returned checks will result in a $25.00 return fee. Failure to meet financial obligations will result in termination of services.

I, _____, (print name) assume all financial responsibility for charges related to all services provided by Cornerstone BH&PT for _____ (print child's name).

_____ _____

Signature of Parent or Guardian Date