Communication & Learning Solutions

Kathleen Rose-Le

Speech-Language Pathologist
M.S. CCC-SLP

3531 Jackson Dr.
Holiday, FL 34691
727-99 2 TALK (8255)
Fax: 727-943-9429
Kathleen@TalkReadKnow.com
WWW.TalkReadKnow.com

Please fill out the enclosed forms as completely as possible. The information you give me helps to determine the most effective methods of evaluation. Your background is utilized in setting goals for therapeutic intervention.

Thank you for choosing my practice to serve your needs.

Your communication to ask any questions or give further input is always welcome.

Sincerely yours,

Kathleen Rose-Le
MS CCC-SLP
Speech Language Pathologist
Certified ASHA member
Certified Orton -Gillingams structured language Therapist
Member International Dyslexia Association
State License number SA4698
Three Time Recipient of the ACE Award
American Academy of Private Practice SLPs
Board Certified Cognitive Specialist (ADHD, anxiety, autism, dyslexia)
PROMPT trained

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Adult Case History Form

Date: _____

Patient Name: _____ D.O.B.___/___/___ Age:_____

Guardian Name (if applicable): _____

Address: _____

_____

Home Phone: (____)_____ Work: (_____)_____

Cell: (____)_____ E-mail: _____

Patient's Social Security # _____-_____-_____ _

Medicaid #: _____

Medicare #: _____

Other Insurance Name: _____

Group/ policy # _____

Name of insured _____

(please provide a photo of front and back of all insurance cards. This can be emailed/faxed/texted)

Day program &/or group home _____

Allergies: _____

Current medications: _____

_____

Primary Physician: _____ Phone # _____

Referred by: _____

Reason for seeking therapy: _____

_____

_____

_____

_____

_____

When did patient last see a dentist? _____

Vision last tested? _____

Results of those tests: _____

_____

Hearing last tested? _____

Results: _____

Please list current and past medical problems, surgeries, illnesses, diseases, and injuries with dates of occurrences: _____

_____

_____

_____

Are there any difficulties with eating/swallowing or had sensitivities to particular foods?

_____

_____

Are you allergic to any foods or other substances? If so, what?

_____

Does the patient display any of these behaviors: (check if observed)

☐ Rocking ☐ Sensitivity to touch ☐ Difficulty with transitions

☐ Jargon ☐ Sensitivity to loud noises ☐ Gags on textured foods

☐ Excessive drooling ☐ Puts non-food items in mouth ☐ Picky eater

☐ Head banging ☐ Clumsy ☐ Attention difficulties

Does the patient have difficulty with:

Following directions: _____ Describing events or thoughts: _____

Responding to questions: _____ Grammar in speech: _____

Interacting with peers: _____

Current modes of communication used (i.e. words, using sentences): _____

_____

_____

How much of the patient's speech do you understand? (25%, 50%, 75% 100%) _____

How much do unfamiliar listeners understand? _____

When you give the patient a list of steps (example: go to the bedroom, turn off the TV, hang up your clothes, then make your bed) will they:

(check all that apply)

-Get to the room and do one thing? ☐ -Get distracted on the way to the room? ☐

-Have no problem at all? ☐ -Get to the room and forget what to do? ☐

-Get to the room and do two things? ☐

Do you follow instructions better if: Hear it ☐ Read it ☐ Watch it ☐

Do you get distracted: Easily ☐ Very Easily ☐ Some ☐ Not at all ☐

Do you have problems completing a task? No ☐ Yes ☐ N/A ☐

Are you overactive or impulsive? No ☐ Yes ☐ N/A ☐

Do you have trouble following verbal directions? No ☐ Yes ☐ N/A ☐

Do you have trouble following written directions? No ☐ Yes ☐ N/A ☐

Do you reverse letters or words? No ☐ Yes ☐ N/A ☐

Do you have difficulty understanding or remembering what someone says? No ☐ Yes ☐

Goals for this evaluation:_____

_____

_____

_____

_____

Questions:_____

_____

_____

_____

Consent For Release of Information

I, _____ authorize Communication & Learning Solutions to release/obtain
Print parent/guardian name
Information regarding:
Client name: _____
Date of birth: _____
City: _____
County: _____
To/from the following institution(s):(Doctor, School, Other Supports)
Name: _____
Address: _____
_____
Name: _____
Address: _____
_____
Name: _____
Address: _____
_____
Name: _____
Address: _____
_____

Specific Information to be discussed in written and/or verbal communication:

1. SLP Evaluations/Progress Reports/Treatment Plans	Release	Obtain
2. Medical Reports/Progress Notes/Treatment Plans	Release	Obtain
3. Vision Reports/Progress Notes/Treatment Plans	Release	Obtain
4. Audiological Evaluations/Progress Notes/Treatment Plans	Release	Obtain

The information obtained/released as a result of this form will be used to provide accurate and comprehensive communication among the service provider team.

This consent for disclosure is valid for one (1) year from the date of signature.

I hereby declare that I understand that I have the right to inspect and receive copy of the information disclosed as a result of this form. I understand that I may withdraw consent at any time by written request. I understand that my refusal to consent to disclosure will not result in any other consequence, but information will not be disclosed.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Witness Date

Send Information to:
Communication & Learning Solutions
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Phone: (727) 992-TALK (8255)
Fax: (727) 943-9429
Email: kathleen@TalkReadKnow.com

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Informed Consent for Therapeutic Services

I, _____, authorize Kathleen Rose-Le to enroll,
Print name of parent/guardian

_____ in Speech-Language Therapy,
Print name of client/child

By consenting to these services I declare that I understand, and agree with the following:

1. Orientation regarding services has been explained to me in language that I can understand.
2. My consent to services is voluntary and can be withdrawn at any time.
3. Written reports/documentation regarding the client/child will not released except to those individuals whom have been named in a written, signed release form to accept such correspondence.
4. The client/child's file will be maintained for seven (7) years after discharge.

I have read the above information and fully understand the services in which I hereby consent. I release the agency and their trustees, officers, agents, and employees from any liability to the client any personal injury or property damage suffered by the client as a result of participation in these services. I assume all responsibility and agree to indemnify the agency and hold the agency harmless from and against any and all liability or costs associated with or arising from the client's participation in these services. In case of accident or sickness, I consent to emergency medical care provided by ambulance or hospital personnel.

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Date

PLEASE PRINT AND THEN SIGN FORMS TO COMPLETE YOUR SIGNATURE. SCAN AND EMAIL BACK TO Kathleen@TalkReadKnow.com IF POSSIBLE.

IF NOT BRING THE SIGNED FORM WITH YOU AT YOUR FIRST APPOINTMENT

Assignment of Benefits

ASSIGNMENT OF BENEFITS ***REQUIRED FOR INSURANCE BILLING***

RELEASE OF INFORMATION I agree to allow Communication & Learning Solutions. Inc., its agents and any of its associated companies (together, "Provider") to share any part of my medical record or other information needed for billing and payment for services delivered by Provider, now or in the future, to any financially responsible party, including: the Centers for Medicare and Medicaid Services (CMS), their agents, Worker's Compensation carriers, health or liability insurers, and any other insurance organization or billing agent (together, "Insurer"). I agree to allow anyone with medical and billing information about me to release to Provider or Insurer any information necessary for billing and payment purposes. I agree a copy of this form may be used instead of the original.

ASSIGNMENT OF BENEFITS & RIGHTS I agree to allow and request any Insurers to directly, immediately and exclusively pay Provider the proceeds of my benefits up to the full amount of Provider's charges for services delivered now or in the future. I assign to Provider all of my rights and interest in all such insurance benefits or proceeds for services delivered by Provider, including the rights to: (1) request and receive any documents or information from any entity or person, including those governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), to the full extent of my rights; (2) appeal any denial or underpayment of benefits or coverage; (3) pursue any legal remedies in any forum and get all available relief (monetary or equitable), including applying all ERISA provisions. These rights assigned to Provider are assigned completely, without any limitations or reservations.

FINANCIAL RESPONSIBILITY I will cooperate with any efforts by Provider to maximize payment of my insurance benefits and minimize my personal financial responsibility. I agree to allow Provider to be my advocate throughout the billing process to help resolve my claim as quickly as possible. If I receive payment from an Insurer for Provider's services, I agree to promptly send such payment to Provider. I understand that many Insurers will only pay for services that meet certain coverage requirements, such as medical necessity. If my Insurer denies or underpays Provider's charges for any reason, or if I have no insurance, I accept direct financial responsibility for any unpaid charges.

COLLECTIONS & TELEPHONE CONSENT I agree to allow Provider to: leave answering machine or voice mail messages for me, and include in any such messages information required by law (including debt collection laws) or other information about amounts I owe; (3) send text messages or e-mails to the telephone number and e-mail address provided below about unpaid balances or other billing issues. I also agree to allow Provider to get a credit report to help collect unpaid balances.

I have read this information and I am the patient, the patient's legal representative or authorized by the patient as the patient's agent to sign this Assignment of Benefits and to accept its terms.

Mark the Appropriate Box and Sign Below: Signer below is the: Patient Insurance Policy Holder Power of Attorney

Signature: _____ Date: ____/____/ _____

Printed Name of Signer: _____

Relationship to Patient: _____

Patient Name (if not signer above): _____ Patient Date of Birth: ____/____/

Last four digits of Patient's Social Security #: _____ Phone: _____

Email:_____

PLEASE PRINT AND THEN SIGN FORMS TO COMPLETE YOUR SIGNATURE. SCAN AND EMAIL BACK TO Kathleen@TalkReadKnow.com IF POSSIBLE.

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