KARA DODDS & ASSOCIATES
PEDIATRIC THERAPY CENTER
SPEECH • OCCUPATIONAL • PHYSICAL

CASE HISTORY REPORTING FORM

PATIENT INFORMATION
ALL SECTIONS MUST BE COMPLETED LEGIBLY

Today's Date _____

☐ New Patient ☐ Name Change ☐ Address Change ☐ Insurance Change

A. Background Information

1. Name _____
2. Date of Birth ___/___/_____
3. Address _____
   City _____ State _____ Zip _____
4. Telephone Home _____ Work _____
   Cellular_____ _____Email _____
5. Parent/Guardian _____
6. Siblings: Name Age Male/Female

   _____

   _____
7. Primary language spoken in the home _____
8. What is the reason for your child's referral to therapy services? _____

   _____
9. Has your child ever received therapy services in the past? _____

   _____

B. Pregnancy History

1. Was mother under doctor's care? Yes ☐ No ☐
2. Did any of the following occur during pregnancy?

	Yes	No		Yes	No
Smoking	☐	☐	Elevated blood pressure	☐	☐
Alcohol/Drug use	☐	☐	Bleeding	☐	☐
Anemia	☐	☐	Threatened miscarriage	☐	☐
Toxemia	☐	☐	Illness/flu	☐	☐
Hospitalization	☐	☐	Other Medical Conditions	☐	☐

Please Describe _____

_____

D. Newborn History

1. Length of pregnancy. Full term _____ Premature _____ Weeks_____
2. How long was labor _____Was the labor induced? Yes ☐ No ☐
3. Type of delivery

   Normal _____ Breech _____ Planned cesarean _____ Emergency cesarean _____
4. Were instruments used during delivery? Yes ☐ No ☐
5. Was the child a twin, triplet, etc. _____
6. Birth weight _____ Apgar score _____
7. Length of hospital stay _____
8. Did your child experience/require any of the following?

	Yes	No		Yes	No
Delayed cry	☐	☐	Jaundice	☐	☐
Required oxygen	☐	☐	HIV	☐	☐
Cord around neck	☐	☐	Difficulty breathing	☐	☐
Incubation	☐	☐	Toxoplasmosis	☐	☐
Difficulty sucking/			Tube feedings	☐	☐
Swallowing	☐	☐			

E. Family & Medical History

1. Has your child received a medical diagnosis? Yes ☐ No ☐

   If yes, please indicate: _____
2. How would you classify your child's general health? Good ☐ Fair ☐ Poor ☐
3. Does your child take any medications? Yes ☐ No ☐

   If yes, please indicate: _____
4. Does your child have allergies? Yes ☐ No ☐

   If yes, please list _____
4. Has your child ever been hospitalized or had surgery? Yes ☐ No ☐

   If yes, please explain _____

   _____
5. Has your child been to a neurologist? Yes ☐ No ☐

   If yes, please state why _____

   _____
6. Has your child ever been to a geneticist? Yes ☐ No ☐

   If yes, please state why _____

   _____

Does <u>your child</u> or a <u>family member</u> have/have a history of any of the following:	**Please Check:**	**If yes, whom?**	**Parent/Guardian Comments**
Seizure Activity	Yes ☐ No ☐		
Birth Defects	Yes ☐ No ☐		
Mental Illness	Yes ☐ No ☐		
Anxiety	Yes ☐ No ☐		
Emotional Disorders	Yes ☐ No ☐		
Intellectual Developmental Disability	Yes ☐ No ☐		
Vision Problems	Yes ☐ No ☐		
Hearing Problems	Yes ☐ No ☐		
Speech Problems	Yes ☐ No ☐		
Learning Problems	Yes ☐ No ☐		
Sensory Problems	Yes ☐ No ☐		
Behavioral Problems	Yes ☐ No ☐		
Autism Spectrum Disorder	Yes ☐ No ☐		
Genetic Condition	Yes ☐ No ☐		
Metabolic Condition	Yes ☐ No ☐		
Asthma	Yes ☐ No ☐		
Sinusitis	Yes ☐ No ☐		
Cleft Palate	Yes ☐ No ☐		
Head Injury/Trauma	Yes ☐ No ☐		
Stroke/Brain Trauma	Yes ☐ No ☐		
Meningitis	Yes ☐ No ☐		
Excessive Mucus/Drooling	Yes ☐ No ☐		
Cancer	Yes ☐ No ☐		
Paralysis	Yes ☐ No ☐		
Rheumatic Fever	Yes ☐ No ☐		
High Fever	Yes ☐ No ☐		
ADHD	Yes ☐ No ☐		

F. Educational History

1. Preschool/School _____
2. Type of classroom _____
3. Please list any special education services your child receives at school. _____

_____

G. General Information

1. What are your primary concerns for your child? _____

   _____

2. Is your child receiving any early intervention or home programs? Yes □ No □ (please list)

   _____

PATIENT NAME: _____

A. Developmental History

1. Please indicate the age at which the patient did the following:

_____ Spoke his/her first 4-10 words (list examples)

_____

_____

_____ Put 2 word combinations together (list examples)

_____

_____

2. Was/Is there an overall delay in speech and language milestones? Yes ☐ No ☐

B. Medical History

1. Is your child prone to ear infections? Yes ☐ No ☐
2. Have tubes placed in his/her ears? Yes ☐ No ☐

   If yes, when? _____
3. Has the patient's hearing been tested? Yes ☐ No ☐

   If yes, when and where? _____

   If yes, what were the results? _____
4. Has the patient had his/her tonsils or adenoids removed? Yes ☐ No ☐

   If yes, when and where? _____

C. Neurological History

1. Has the patient been to a neurologist? Yes ☐ No ☐

   If yes, please explain _____

   _____
2. Has the patient been to a geneticist? Yes ☐ No ☐

   If yes, was your child diagnosed with a syndrome? Yes ☐ No ☐
3. Has the patient ever been hospitalized? Yes ☐ No ☐

   If yes, please explain _____

D. Feeding History

1. Does the patient display any of the following?

   Excessive drooling Yes ☐ No ☐

   Difficulty chewing and/or swallowing Yes ☐ No ☐

   Difficulty gaining weight Yes ☐ No ☐

   Regurgitation of liquids/solids Yes ☐ No ☐

2. Did the patient ever receive tube feedings? Yes ☐ No ☐

   If yes, please explain _____

   _____

3. Do you consider the patient to be a picky eater? Yes ☐ No ☐

   If yes, please explain and list examples of what he/she will and will not eat

   _____

   _____

E. Preferences & Goals

1. Does the patient have any extreme likes or dislikes? Please explain _____

   _____

2. What areas do you feel need to be targeted with the patient? _____

   _____

   _____

Office Insurance Policy

Insurance covering speech therapy, physical therapy and occupational therapy services is a highly complex area that creates confusion for many families. The following information will give you some general knowledge about insurance and our office policy on insurance.

Insurance coverage for therapy services is a contract between your employer and an insurance company. The insurance benefits that your child/children receive are based on terms of the contract that were negotiated between your employer and the insurance company not Kara Dodds and Associates, Inc. office. The goal of most insurance policies is to provide only basic care for specific services. The services selected are based on the cost of the policy to your employer and the negotiated arrangements with the insurance company.

Because the benefits you currently have are decided between your employer and the insurance company, many services are not covered. Insurance companies rarely cover 100% of therapy services, and in most cases, cover less than 50% or nothing at all. The selection of non-covered services is based strictly on the contract with the insurance company, and not on what you want or need for your child/children. Our goal is to help your child/children receive the therapy services that are needed. The goal of the insurance company is to provide only the negotiated benefits for the specifically selected services.

Our office will do everything possible to help you understand and make the most of your insurance benefits. We take extra time in obtaining your insurance information prior to your child/children's appointment so that we may provide you with an accurate estimate of your insurance coverage. Our office will also complete and submit insurance forms as a courtesy to our clients. Although we do our best to give you the most accurate estimate based on the information gathered from your insurance company, the ultimate responsibility for payment of your child/children's therapy services belongs to the parent(s).

We are dedicated to providing therapy services for your child/children and working with you to achieve their goals. We pride ourselves on helping you in any way, and in continuing to provide the highest quality of care for your child/children. Please let us know if you have any questions – it will be our pleasure to help you.

I acknowledge that I have read and understand Kara Dodds and Associates, Inc. Office Policy on insurance, and I am responsible for any payment of my child/children's treatment not covered by my (or my spouse's) insurance.

_____ _____

Signature Date Print Child's Name

_____

Print Name

Kara Dodds and Associates, INC.

Privacy Policies

This notice describes how information about you (as a client) may be used and disclosed and how you may get access to your information. This is required by the Privacy Regulations created as a result of the Heath Insurance Portability and Accountability Act of 1996 (HIPPA).

Our commitment to your privacy

Kara Dodds and Associates is dedicated to maintaining the privacy of your information. We are required by law to maintain the confidentiality of your information.

Use and disclosure of your information in certain circumstances

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or another individual or to the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement.
8. For workers compensation and similar programs.

Your rights regarding your information

1. You can request that Kara Dodds and Associates communicate with you about your health related issues in a particular manner or at a certain location; for instance, if you ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment or health care. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care, such as family members and friends. We are not required to agree to your request, however, if we do agree, we are bound by our agreement to accept when otherwise required by law, in emergencies or when the information is necessary to treat you.

3. You have a right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Kara Dodds and Associates.

4. You may ask us to amend your health information if you believe it is untrue or incomplete, and as long as the information is kept by or for our offices. To request an amendment your request must be submitted in writing to HIPPA Compliance Officer and Kara Dodds and Associates. You must provide us with a reason that supports the request.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to obtain a copy of this notice at any time. To obtain a copy, please contact our receptionist.

6. If you believe that your privacy has been violated, you may file a written complaint with our office or with the Secretary of the Department of Health and Human Services.

7. Kara Dodds and Associates will obtain your written authorization for uses and disclosures that are not identifies by this notice or permitted by applicable law.

If you have any question regarding this notice please contact our offices.

_____	_____	_____
Signature of Client or Gaurdian	Name of Client	Date

Kara Dodds and Associates, Inc.
7840 Mission Center Ct Ste 200
San Diego, CA 92108
PH : 619-692-0622 FAX: 619-692-0644

FINANCIAL POLICY AGREEMENT

Welcome! Please take the time to review the following policies and procedures that we at Kara Dodds and Associates, Inc. have set in place to better serve you. We look forward to establishing a long and wonderful relationship with you.

AVAILABLE PAYMENT OPTIONS
CASH, CHECK, ATM, CHARGE (VISA, MASTERCARD, AMERICAN EXPRESS) A credit card **MUST** be placed on file for any no show appointments/late cancellations and co-pays or invoices that may become delinquent or past due.

PAYMENT POLICY
Payment is due and payable, in full, at the time services are rendered, unless other arrangements are made prior to receiving these services. This includes private paying clients, co-payments and other share-of-cost fees. If payment is not received at the time of service, those paying Cash Rates will be charged for services at the Regular Office Rates. (A current fee schedule is located on the front desk for your review of our rates). It is your responsibility to be aware of the amount and to pay all co-payments associated with the services we provide, even if you are not directly requested to do so. The Receptionist is available to receive all payments. When payment is received, you will be given a receipt to verify your payment.

MISSED APPOINTMENT POLICY
Chronically missing appointments may result in the cancellation of standing appointments. Standing appointments may also revert to the on-call list after two cancellations. Resumption of therapy will be at the sole discretion of the therapist and subject to a "paid in full" status of your account.

RETURNED CHECK POLICY
There is a $25.00 charge, which will be added to your account for each check returned to us by the bank.

FINANCE CHARGE POLICY
All unpaid, past due balances will have a 1.5 % Finance Charge added to the past due amount. A $20.00 per month administrative charge will be added to all accounts over 60 days old. On the 61st day, a Finance Charge of 1.5% APR will be assessed on the unpaid balance after the $20.00 administrative charge has been added.

INSURANCE COVERAGE POLICY
IT IS YOUR RESPONSIBILITY TO OBTAIN PAYMENT FROM YOUR INSURANCE CARRIER. We will assist you, upon request as a courtesy by explaining typical procedures, coverage requirements and we can provide you with all the necessary documentation so that you may receive your reimbursement in a timely fashion. We reserve the right to waive this policy and to bill your insurance company directly. This is done on a case-by-case basis and must be authorized by the Kara Dodds and Associates Office Manager. Please be aware that an authorization from your insurance company for treatment is not a guarantee of payment. If it is determined, after services have been provided in good faith, that your insurance does not cover the incurred charges, you agree to be responsible for the immediate payment of all monies owed. You will be asked to verify coverage each month by submitting you Insurance Card or Treatment Authorization form.

I understand and agree to abide by all the conditions and obligations described above and my signature below signifies that I agree to enter into this service contract with Kara Dodds and Associates to provide the services I have requested and/or authorized. Further, my estimated co-payment of $_____ per visit is due at the time services are provided.

I further declare that I have verified that my insurance provider has approved the balance of the incurred fees for payment. Nonetheless, should my insurance provider not make payment for the balance due, I agree to be responsible for the unpaid balance.

All cancellations must be within 24 hours or will be subject to a $30 no-show fee. _____ (parent initials)

_____	_____	_____
Parent/Guardian/Responsible Party	Print Patient Name	Date

Revised 9-2013

Kara Dodds and Associates, Inc.
7840 Mission Center Ct., Suite 200
San Diego, California 92108
619-692-0622
FAX 619-692-0622

CONSENT TO OBTAIN INFORMATION

This form when signed and completed by you authorizes Kara Dodds and Associates, Inc. to request protected, psychological and educational information about you and your child to other parties.

_____
Patient Name

_____
Date of Birth

We request your permission to obtain information from the following sources;

1. Pediatricians or other medical personnel involved with your child's care
2. Teachers or school administrators that have worked with your child
3. Psychologists of psychiatrists who have worked with your child
4. Speech, Occupational and Physical Therapists that have worked with your child
5. Service coordinators or case managers that have worked with your child
6. Early Intervention Agencies and Insurance Agencies who have worked with your child

This release is subject to the following limitations:

_____

_____

I understand that all information held by Kara Dodds and Associates, Inc. is strictly confidential. I understand that I have the right to revoke or modify this authorization at any time.

Signed: _____ Witness:_____

Date: _____

Kara Dodds and Associates, Inc.
7840 Mission Center Ct., Suite 200
San Diego, California 92108
619-692-0622
FAX 619-692-0644

CONSENT TO RELEASE INFORMATION

This form when signed and completed by you authorizes Kara Dodds and Associates, Inc. to release information about you and your child to other parties.

Note: Evaluation and Update written reports will be automatically send to the funding agency. You grant Kara Dodds and Associates, Inc. to forward these funding agencies when you affix your signature below.

_____
Patient Name

_____
Date of Birth

I authorize the personnel of Kara Dodds and Associates, Inc. to release information about me and my child to the following. I understand that all information held by Kara Dodds and Associates, Inc. office is strictly confidential.

NAME	ADDRESS	CITY	STATE	ZIP

This release is subject to the following limitations:

_____
_____

I understand that I have the right to revoke or modify this authorization at any time.

Signed: _____ Witness:_____

Date: _____

Kara Dodds and Associates, Inc.
7840 Mission Center Ct. Suite 200
San Diego, CA 92108
619-692-0622 FAX 619-692-0644
www.karadodds.com

WAIVER OF LIABILITY

We at Kara Dodds and Associates, Inc. are committed to providing a safe and comfortable environment for all of our clients. However, we DO NOT assume responsibility for the supervision of minors or dependent adults. Therefore, the responsible agent for a minor child or dependent adult brought to Kara Dodds and Associates, Inc. by their signature hereon expressly saves and holds harmless the personnel of Kara Dodds and Associates, Inc. for any consequences that might arise as a result of medical condition(s) known, unknown, disclosed or undisclosed, while they are attending a regularly scheduled appointment.

It is imperative that minor children and dependent adults never be left unsupervised during your visit to our clinic. Should the responsible agent of the dependent minor or adult leave the premises for any reason, they remain solely and completely responsible for the supervision and care of the minor or dependent adult left in their charge. Therefore, as a responsible precaution, we request that you remain at our office for the duration of the scheduled appointment.

Nevertheless, should a medical emergency arise in your absence, we will exercise due diligence to notify the emergency personnel whom you have requested be contacted should such an incident occur. Notwithstanding our commitment to contact the personnel identified below, should we be unable to do so, the staff of Kara Dodds and Associates will use their best judgment to ensure the safety of our clients. We will do this by acting in a manner that we believe is appropriate given the circumstances at hand.

We at Kara Dodds and Associates, Inc. have adopted this policy solely for the protection of your child and/or dependent adult. Therefore, we request that you make your best effort to assist us in ensuring the safety of your child and/or dependent adult by abiding by the specific provisions contain herein and by being responsive to the intent expressed and implied in this Waiver of Liability policy.

Should a medical emergency occur, I request that the personnel of Kara Dodds and Associates, Inc. notify the following person(s) / agency(s):

Name	Relationship	Telephone #1	Telephone #2

Signature of Parent/Guardian/Responsible Party Date

Release for Use of Images

I hereby give my consent to Kara Dodds & Associates to photograph, film, videotape and then use, reproduce, and publish said images of me and/or my child/children.

_____

(Please print parent/guardian's name)

_____

(Please print child's name)

I agree that photographs/negatives, film, or videotapes thereof shall constitute the sole property of Kara Dodds & Associates, with full right of disposition in any manner whatsoever, including the right to publish on Kara Dodds & Associates website (https://karadodds.com).

I hereby release Kara Dodds & Associates and his/her legal representatives and assigns from any and all claims whatsoever in connection with the use, reproduction, publication of the images thereof.

_____

Signature

_____

Signature for minor child

_____

Title/Organization

_____

Address *Phone*