THE CARRUTH CENTER
AT THE PARISH SCHOOL

Speech-Language Therapy Intake Packet

- Speech Case History
- Authorization for Emergency Medical Attention
- Consent For Treatment
- Speech Payment Contract & Authorization
- Carruth Center Policies Form
- Authorization To Use or Disclose Protected Health Information
- The Carruth Center Notice of Privacy Practices
- Schedule of Fees

THE CARRUTH CENTER
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Case History

Date:_____ Information provided by:_____

Child's Name:_____
First Middle Last Nickname

Address:_____
City State Zip Code

Home Telephone Number:_____

Birth Date:_____ Age:_____ Gender: ☐ Male ☐ Female

Who has legal custody of this child?_____

Is this child adopted?_____ At what age?_____ Is he/she aware of this?_____

Father's Name: _____ Date of Birth:_____

Home Address:_____
(if different) City State Zip Code

Contact Numbers: Cell:_____ Work:_____ Home:_____

Email Address: _____

Marital Status: ☐ married to child's mother (biological or adoptive) ☐ single ☐ separated ☐ divorced ☐ widowed ☐ remarried

PLEASE NOTE IF YOU ARE DIVORCED WE WILL NEED A COPY OF YOUR DIVORCE DECREE

Occupation:_____ Place of Occupation:_____

Education/Highest Degree:_____

Mother's Name:_____ Date of Birth:_____

Home Address:_____
(if different) City State Zip Code

Contact Numbers: Cell:_____ Work:_____ Home:_____

Email Address: _____

Marital Status: ☐ married to child's father (biological or adoptive) ☐ single ☐ separated ☐ divorced ☐ widowed ☐ remarried

Occupation:_____ Place of Occupation:_____

Education/Highest Degree:_____

Please list the occupants of your child's household:

Household 1:_____

Name	Age	Relationship to child

Household 2:_____

Name	Age	Relationship to child

Does either parent have children from previous relationships? If so, please list names and ages below:

Mother: _____

Father: _____

Is any language other than English spoken in the home? _____ If so, which? _____

Who referred you to The Carruth Center? _____

FAMILY HEALTH HISTORY, MENTAL ILLNESS, AND/OR DEVELOPMENTAL PROBLEMS:

Please check 'Yes' or 'No' for each of the medical conditions below which apply to a family member, then list relation to the child on the right (e.g., mother, brother, paternal grandfather, maternal uncle, etc.)

Yes	No		Yes	No	
☐	☐	Thyroid _____	☐	☐	Post-partum depression _____
☐	☐	Heart disease _____	☐	☐	Nervous breakdown _____
☐	☐	High blood pressure _____	☐	☐	Emotional problems _____
☐	☐	Vision problems _____	☐	☐	Delinquency problems _____
☐	☐	Seizures _____	☐	☐	Substance abuse _____
☐	☐	Birth defects _____	☐	☐	Alcoholism _____
☐	☐	Mental retardation/Down's syndrome _____	☐	☐	Bed-wetting after 5 years _____
			☐	☐	Hyperactivity/ADHD _____
☐	☐	Kidney disease _____	☐	☐	Schizophrenia _____
☐	☐	Cancer _____	☐	☐	Learning problems (please specify) _____
☐	☐	Sudden death _____			_____
☐	☐	Hearing problems _____	☐	☐	Bipolar disorder _____
☐	☐	Cerebral palsy _____	☐	☐	Autism/PDD _____
☐	☐	Arthritis _____	☐	☐	Speech problems/delays _____
☐	☐	Diabetes _____	☐	☐	Eating disorder (Anorexia/Bulimia) _____
☐	☐	Depression _____			
☐	☐	Anxiety _____	☐	☐	Obsessive compulsive disorder _____
		Please list any other diseases that run in the family _____ _____	☐	☐	Phobias _____
			☐	☐	Other (please specify) _____ _____

CURRENT CONCERNS:

Please check below if you have any concerns about your child in these areas:

☐ Short attention span	☐ Attention seeking	☐ Distractibility
☐ Impulsivity	☐ Hyperactivity	☐ Avoidance
☐ Low frustration tolerance	☐ Noncompliance	☐ Anxiety
☐ Oppositional behavior	☐ Social isolation	☐ Low self-esteem
☐ Aggression	☐ Lying	☐ Awareness of differences
☐ Difficulties with transitions	☐ Self-stimming	☐ Difficulties separating

Please list any additional concerns about your child: _____

_____

When did these problems begin? _____

PRENATAL AND PERINATAL HISTORY:
Was this a planned pregnancy: ☐Yes ☐No Fertility treatment? _____

MEDICAL HISTORY DURING PREGNANCY:
Please check the following conditions that may have occurred during this pregnancy, and explain in the space below:

Yes	*No*		*Yes*	*No*	
☐	☐	Edema (swelling of the hands and feet)	☐	☐	Epilepsy (seizure)
☐	☐	Vaginal bleeding	☐	☐	Infections (colds, flu, urinary tract, rubella)
☐	☐	Toxemia	☐	☐	Other illnesses (specify below)
☐	☐	High blood pressure	☐	☐	Operations (specify below)
☐	☐	X-ray studies	☐	☐	Injuries (specify below)
☐	☐	Hospitalization	☐	☐	Tobacco/alcohol/controlled substance abuse
☐	☐	Fever			Frequency_____
☐	☐	Diabetes			

Please explain all "yes" answers: _____

_____

_____

_____

BIRTH HISTORY:

Length of Labor: _____

Type of labor onset: ☐ Induced ☐ Spontaneous
Type of birth: ☐ C/Section ☐ Vaginal
Type of anesthesia: ☐ Gas ☐ Spinal epidural ☐ Local epidural

Was the baby on time? ☐ Yes ☐ No
If "no", was he/she ☐ Early ☐ Late By how many weeks? _____

Age of father at birth: _____ Age of mother at birth: _____ Number of children born: _____

Check if any of the following problems occurred during labor:

Yes	*No*		*Yes*	*No*	
☐	☐	Toxemia/eclampsia	☐	☐	Fetal distress
☐	☐	Maternal fever	☐	☐	Medications used

How much did your child weigh? _____
Apgar Scores: _____

Check if any of the following problems occurred after the child's birth.

Yes	*No*		*Yes*	*No*	
☐	☐	Trouble breathing	☐	☐	Jaundice
☐	☐	Cord around the neck	☐	☐	Poor feeding
☐	☐	Fever	☐	☐	Vomiting
☐	☐	Hemorrhage (bleeding) in head	☐	☐	Floppy
☐	☐	Large ventricles (hydrocephalus)	☐	☐	Incubator care
☐	☐	Cyanosis (turned blue)	☐	☐	Infection
☐	☐	Need for ventilation/oxygen	☐	☐	Other_____

Please explain all "yes" answers:_____

_____

_____

How many days after birth was mother discharged from hospital? _____
How many days after birth was child discharged from hospital? _____

Previous Obstetrical History:

How many full-term pregnancies has mother had? _____
What were the dates? _____
Any abortions, miscarriages, or stillbirths? _____
What were the dates? _____

CHILD DEVELOPMENT:

Was your child breast-fed? ☐ Yes ☐ No
Duration? _____
Describe the circumstances around stopping: _____
Describe the weaning: _____

Was your child bottle-fed? ☐ Yes ☐ No
Duration? _____
Describe the circumstances around stopping: _____

Please check any of the following that described your child as an infant:

☐ Fussy	☐ Sleeping problems	☐ Reflux
☐ Easy to soothe	☐ Feeding problems	☐ Failure to thrive
☐ Difficult to soothe	☐ Cried excessively	☐ RSV
☐ Startled easily	☐ Colic	☐ Other_____

What are your child's sleeping arrangements?
☐ room alone ☐ with sibling ☐ with parents ☐ with others

Does your child sleep in: ☐ crib ☐ bed

Does he/she sleep through the night? ☐ Yes ☐ No
If not, how many times does he/she awaken at night? _____
For how long? _____
What helps him/her get back to sleep? _____

Did/does your child have a special object (blanket, teddy bear, etc.)? ☐ Yes ☐ No
If yes, please describe _____
If yes, until what age? _____

Does he/she have any self-soothing behavior? ☐ Yes ☐ No
If yes, does he/she: ☐ suck fingers/thumb ☐ use pacifier ☐ twirl hair
☐ other, please describe _____

Does your child exhibit any behaviors that you consider 'odd' or 'unusual'? _____

How many hours of TV and/or video does your child watch each day? _____
What are his/her favorites? _____

Developmental Milestones (age of mastery):
When did your child do the following (please list specific age, if possible):

	Early	Late	On time	Age
Smile				
Laugh				
Maintain eye gaze				
Imitation				
Gestures (pointing)				
Roll over				
Sit				
Crawl				
Stand				
Walk				
Wave Bye-Bye				
Toilet trained (day)				
Toilet trained (night)				
Babbling				
Cooing				
First words				

What were your child's first words? _____

When did your child put two words together? _____

Could you understand your child's speech by age 2? ☐ Yes ☐ No
Could others understand your child's speech by age 2? ☐ Yes ☐ No
Could your child speak in simple sentences by age 2? ☐ Yes ☐ No
Does your child recite scripts from movies or TV? ☐ Yes ☐ No
How does your child typically communicate? ☐ Gestures ☐ Words ☐ Sentences

Please describe any areas of concern (articulation, socialization, receptive language, expressive language, echolalia (parroting what is said)):_____

When did your child begin the following (please list specific age, if possible):

	Early	Late	On time	Age
Use writing utensils				
Use eating utensils				
Run smoothly				
Snap				
Button				
Zip				
Jump with two feet				
Tie shoes				
Climb play equipment				
Ride a bike: tricycle				
Training wheels				
Two-wheeler				
Skip with coordination				

Please describe any areas of concern (i.e., fine or gross motor, balance)_____

Did your child do any head-banging?_____ At what age?_____

Is he/she left-handed or right-handed?_____ Does he/she change from hand to hand?_____

MEDICAL HISTORY:

Child's Physician:_____ Telephone #:_____

What major illnesses, hospitalizations, or operations has your child had? Please explain when the incident happened, what occurred, and how your child and each parent experienced this event.

Do you have any concerns about your child's physical health? ☐ Yes ☐ No
If "yes," please describe: _____

When was your child's last physical exam? _____

Please check which of the following your child has had and note the age, complications and frequency below:

Yes	No		Yes	No	
☐	☐	Measles	☐	☐	Mumps
☐	☐	Chicken pox	☐	☐	Pneumonia
☐	☐	Whooping cough	☐	☐	Viral infections
☐	☐	Trauma (broken bones/stitches)	☐	☐	Hospitalizations
☐	☐	Concussions (age and treatment)	☐	☐	Surgery
☐	☐	Hearing problems	☐	☐	Asthma
☐	☐	Allergies	☐	☐	Tremor
☐	☐	Meningitis (viral/bacterial)	☐	☐	RSV
☐	☐	Persistent high fever	☐	☐	Coma
☐	☐	Convulsions	☐	☐	Head trauma
☐	☐	Loss of consciousness	☐	☐	Bed-wetting
☐	☐	Staring spells	☐	☐	Stool soiling
☐	☐	Accidental poisoning	☐	☐	Bowel problems
☐	☐	Vision problems	☐	☐	Frequent falling
☐	☐	Floppy	☐	☐	Excessive vomiting
☐	☐	Seizures	☐	☐	Anemia
☐	☐	Headaches	☐	☐	Medication for convulsion
☐	☐	Ear infections: How many? _____	☐	☐	Medication for hyperactivity
☐	☐	Other infections (specify below)	☐	☐	Medication for other illnesses (not other long-term medical complaints/problems including colds or ear infections)
☐	☐	Tics			
☐	☐	Pica (eating nonfood items, such as dirt or paper)			

Please explain all "yes" answers, including age and treatment for each. _____

_____

_____

_____

Please list all medication and the dosage your child has taken or is currently taking. _____

_____

_____

_____

Has your child had a neurological examination? If so, where and when? What were the results? _____

_____

_____

Has your child had a psychological examination? If so, where and when? What were the results? _____

_____

SOCIAL/BEHAVIORAL HISTORY:

How does your child get along with immediate family?_____

_____

Does your child play well with siblings?_____

Does your child prefer to play alone?_____

Does your child prefer to play with children: ☐ older ☐ younger ☐ same age peers

Is your child aware of his/her difficulties?_____

What are your child's favorite activities?_____

_____

What methods of discipline are used?

- ☐ Rewards
- ☐ Time out
- ☐ Avoidance of child
- ☐ Other _____
- ☐ Verbal reprimands
- ☐ Removal of privileges
- ☐ Physical punishment

What are your child's reactions to discipline?_____

_____

Who is usually responsible for discipline?_____

How would you describe the effectiveness of the current parenting strategies in your home? _____

_____

_____

Please check all that apply to your child:

- ☐ Quiet
- ☐ Sensitive to change in routine
- ☐ Daydreams
- ☐ Irritable
- ☐ Sensitive to certain clothing/textures
- ☐ Dislikes being touched
- ☐ Resistant to change
- ☐ Unusual sexual behavior
- ☐ Other:_____
- ☐ Happy
- ☐ Sensitive to loud noises
- ☐ Withdrawn
- ☐ Aggressive
- ☐ Unusual fears
- ☐ Hyperactive
- ☐ Affectionate

Please describe the frequency of the following behaviors:

	Never	Sometimes	Often
Active	☐	☐	☐
Loud and noisy	☐	☐	☐
Difficulty making transitions	☐	☐	☐
Sensitive to light	☐	☐	☐
Sensitive to smells	☐	☐	☐
Cries easily	☐	☐	☐
Clingy	☐	☐	☐
Entertains him/herself	☐	☐	☐
Gets angry easily	☐	☐	☐
Temper-tantrums	☐	☐	☐
Shy or slow to warm up to new adults	☐	☐	☐
Shy or slow to warm up to new children	☐	☐	☐
Physically cautious	☐	☐	☐
Takes risks that endanger his/her safety	☐	☐	☐
Sad	☐	☐	☐
Aggressive	☐	☐	☐

If your child is aggressive, does he/she
☐ hit ☐ bite ☐ kick ☐ destroy property ☐ other?_____

EDUCATIONAL HISTORY:

Name of current school placement and grade/class:_____

In your child's classroom, what is the number of: Teachers_____

Assistants_____

Students_____

How is your child progressing?_____

Has he/she repeated any grades? If so, which?_____

With what area(s) has your child had particular difficulty?_____

_____

Has your child had special help through the school? If so, describe._____

_____

How does he/she child feel about school?_____

What are your child's favorite subjects?_____

Do you think your child's teacher likes him/her?_____

Does the teacher describe your child with any of the following comments (please check):

	Never	Sometimes	Often
Cannot follow directions	☐	☐	☐
Cannot sit still	☐	☐	☐
Seems to be daydreaming	☐	☐	☐
Learns best using multi-sensory approach	☐	☐	☐
Learns best auditorily	☐	☐	☐
Learns best visually	☐	☐	☐
Picks on other children	☐	☐	☐
Is aggressive	☐	☐	☐
Is sneaky	☐	☐	☐
Has a difficult time expressing his/her thoughts	☐	☐	☐
Doesn't seem to comprehend what's said	☐	☐	☐
Cannot complete tasks	☐	☐	☐

What do you feel are your child's strengths?_____

_____

Other Professionals:
List other professionals (speech-language pathologists, psychologists, psychiatrists, neurologists, tutors, educational diagnosticians, etc.) your child has seen in the past or is currently seeing:

Name	Telephone number	Dates under care	Current appointment days and times	Reason for seeing

Has your child ever been in any type of specialized educational/therapy program? If so, how long?

	Where	Duration
Early Childhood Intervention (ECI)		
PPCD Class		
Speech & Language Therapy		
Physical Therapy		
Occupational Therapy		
Psychotherapy		
Gifted and Talented		
Other (please specify)		

Please use this area for any additional comments or concerns:

THE CARRUTH CENTER
AT THE PARISH SCHOOL

Authorization for Emergency Medical Attention

Child's name (print):_____ Date of birth:_____

Mother's cell #: _____ Father's cell #: _____

Mother's work #: _____ Father's work #: _____

Mother's home #: _____ Father's home #:_____

In the event that we cannot be reached to make arrangements for emergency medical attention, we authorize Karen Dickerson, Clinical Director, or a designated staff member to take my child to the location listed below, or to the nearest hospital, and we give our consent for any and all necessary treatment:

Doctor:_____

Address: _____

_____

Phone #: _____

In case of emergency treatment, please inform the medical staff that our child has the following allergies and takes the following medication(s) on a daily basis (include dosage):

Allergies: _____

Medications: _____

Please list two (2) people who we may contact in the event of an emergency:

Name	Phone	Relationship
Name	Phone	Relationship

Signature _____ Date _____

THIS FORM MUST BE KEPT UPDATED AT ALL TIMES

THE CARRUTH CENTER
AT THE PARISH SCHOOL

Consent for Treatment

Client: _____ Date of Birth: _____

Parent/Guardian: _____ Relationship to Client: _____

I, _____, hereby give consent for the above named child and/or myself to receive services at the Carruth Center of The Parish School. This consent is given until I give notice that these services are no longer requested or until Carruth Center of The Parish School professionals notify me these services will no longer be provided. I certify that I have legal responsibility for this child and am authorized to seek and consent treatment for him/her. I understand that all information provided to Carruth Center of The Parish School professionals is confidential and will generally be released to others only with my written consent. I understand that Carruth Center of The Parish School professionals are required to disclose confidential information without my consent in certain circumstances which includes, but is not limited to, 1) if is determined there is a probability of imminent physical injury by my child to himself/herself or other(s), or if there is a probability of immediate mental or emotional injury to my child 2) if the disclosure is required or authorized by law, legal proceedings, or court order 3) to qualified individuals, corporations, or governmental agencies involved in paying or collecting fees for mental or emotional health services for my child 4) to other professionals and personnel, under the direction of Carruth Center of Parish School professionals providing services to my child, who participate in the diagnosis, evaluation, or treatment of my child 5) a judicial or administrative proceeding brought against Carruth Center of The Parish School professionals by myself or my child 6) in the event it is believed my child is the victim of physical abuse, sexual abuse, or neglect, or if my child divulges information about the physical abuse, sexual abuse, or neglect of a child, elder, or disabled person.

The professionals rendering services through Carruth Center of The Parish School are dedicated to using established and empirically supported psychological, behavioral, and educational evaluation and intervention procedures to optimize the social, emotional, and cognitive development of each child. In the event a child presents as an immediate danger to himself/herself, others, or property, the least restrictive intervention shall be utilized to provide safety for the child, others, or property. While verbal mediation will be the primary intervention utilized, at times physical contact may be required to provide safety for the child, others, or property.

My signature on this document indicates I have read the above information and have a clear understanding of the procedures, policies, and therapeutic interventions described. I have been given the opportunity to have my questions answered regarding the above-described information. I understand that I have the right to withdraw treatment for my child at any time.

_____ _____

Signature of Parent/Guardian Date

THE CARRUTH CENTER
AT THE PARISH SCHOOL

Payment Contract and Authorization
Speech Therapy

Client's (Child's) Name: _____

The fees for the Speech Therapy sessions are invoiced on or around the **5th** day of the month following the last session of the previous month. Payment for these sessions will be direct debited from your account or charged to your credit card on or around the **15th** day of the following month (or the next business day), depending on the selection below and payment authorization information provided.

Speech Therapy Evaluation with a report is $400.00.

Individual Speech Therapy is $135.00 per hour-long session.

_____ Please charge my **credit card** (complete the credit card authorization on following page).

_____ Please **direct debit** my account (complete the ACH direct debit on following page).

In consideration for the acceptance and enrollment of _____ in individual treatment, or group program, I (we) the undersigned parent(s), and/or guardian, or other endorser hereof, promise to pay to the order of Carruth Center, Inc. all applicable fees charged for services rendered due on/or before the fifteenth of the month following treatment. Outstanding balances may result in suspension of services until total account balance has been cleared. There will be a $20.00 service charge for NSF checks. Please initial below.

_____I understand that the form or payment on file must be kept current. To update your form of payment on file, submit a new "Payment Contract & Payment Authorization" form to the Carruth Center, Inc. Business Office before the 15th of the month.

_____I authorize the Carruth Center, Inc. to charge the agreed upon credit card or ACH debit on or around the 15th of each month for services provided during the previous months (generally on going individual services) OR on the dates specified in the payment option selected on the signed contract for services (generally group therapy).

_____I agree that if initial payment processing is declined for any reason, Carruth Center, Inc. may continue to process the payment against the card on a regular basis, until the payment is successfully processed and the balance is resolved. Reoccurring payment declines will result in payments being due at the time of service. In this circumstance acceptable form of payment would be exact cash or a credit card that can be successfully processed at the time of service.

_____I acknowledge and understand the cancellation, late arrival, and late pick-up policies. See Carruth Center Policies form.

See reverse side for payment authorization form
Carruth Center, Inc. must have a current form of payment on file for all clients.

Client's (Child's) Name: _____

Credit Card Authorization:

____ Visa ____ MasterCard ____ American Express ____ Discover

Credit Card Number: _____

Expiration Date: _____ Card Security Code (CSC): _____

Name on Card: _____

Address: _____

_____

ZIP Code: _____

Phone Number: _____

ACH Direct Debit Authorization:

____ Checking Account ____ Savings Account

Depository Name _____ Branch _____

City _____ State _____ Zip _____

Routing Number _____ Account Number _____

_____I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. Law.

Attach a blank voided check

Signature Authorization

This Authorization is to remain in full force and effect until Carruth Center, Inc. has received written notification from me (I or either of us) of its termination in such time and in such manner as to afford Carruth Center, Inc. and DEPOSITORY a reasonable opportunity to act on it.

Print Name: _____

Date: _____ Signature: _____

THE CARRUTH CENTER
AT THE PARISH SCHOOL

Carruth Center Policies Form

Client's (Child's) Name: _____

Please read carefully, and initial each line.

____ Clinic Visitation Policy:

- Children in the lobby must be accompanied by an adult at all times.
- Please check in with The Carruth Center office before entering the therapy area. All parents and visitors must wear a visitor badge while in The Carruth Center therapy area.
- Group observations must be scheduled through The Carruth Center business office at least 24 hours in advance.

____ Cancellation Policy:

Any cancellation, not due to illness or family emergency, must be made by notifying the treating clinician 24 hours in advance. Failure to cancel without 24 hours notice will result in a charge of 100% of the session fee. The Carruth Center reserves the right to dismiss a client from therapy for inconsistent attendance and withhold all test results and reports when professional fees are not paid.

____ Late Start Policy:

Late arrivals will not be accommodated by extending therapy time, and full session fees will apply. For example: If a client is 5 minutes late to their scheduled appointment time, the result will be a 30-minute session fee, even though it was only a 25-minute therapy session. Clients are encouraged to arrive 5 minutes prior to their scheduled session time.

____ Late Pick-up Policy:

Parents are expected to be in The Carruth Center lobby or front porch area prior to the end of their child's therapy session. **The Carruth Center late pick-up policy is as follows:**

- Client families will be given two "passes" (no charge assessed) per fiscal year (August 1st – July 31st) for late pick-up not to exceed 5 minutes.
- Late pick-ups **beyond 5 minutes or post two "passes"** will be charged by the quarter-hour at the standard individual therapy rate. See list of therapy rates below.
- Chronic tardiness may lead to parent being required to remain on campus throughout therapy session.

- Late fees will be included in monthly invoices. Failure to resolve fees with regularly scheduled monthly payment processing, on or around the 15th of every month, will result in suspension of client services.
- Late pick-up fees are not eligible for insurance reimbursement.

Breakdown of Late Fees

	Speech, OT, and Music Individual Therapy Rates ($135.00)	Mental Health Individual Therapy Rates ($140)
5-15 Minutes	$33.75	$35.00
16-30 Minutes	$67.50	$70.00
31-45 Minutes	$101.25	$105.00
46-60 Minutes	$135.00	$140.00

____ **Policy on Insurance:**

- The Carruth Center is a fee-for-service facility and families are responsible for all payments.
- The Carruth Center does not guarantee coverage and/or the ability to gain coverage of services. Coverage is determined by your individual insurance policy.
- The Carruth Center is considered out-of-network. Therefore, we ask that families act as the liaison for any direct communication with their insurance companies.
- The Carruth Center does not submit claims on behalf of the client.
- The Carruth Center provides invoices and/or services descriptions on forms with necessary codes, clinician information, and clinic information for your convenience and ease of filing claims.
- The Carruth Center does not accept payment from insurance companies. All insurance checks issued to The Carruth Center are returned to the insurance company with a request to issue payment to the insured. The insured is then notified by letter and provided a copy of the check for their records.

Parent Name (Print): _____ Date: _____

Signature: _____

THE CARRUTH CENTER
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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Texas law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

Information regarding patient for whom authorization is made:

Full Name: _____

Other Name(s) Used: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: (_____) _____ Email (*Optional*): _____

Information regarding health care provider or health care entity authorized to disclose this information:

The Carruth Center (Initial. Specify if needed) _____
The Parish School (Initial. Specify if needed) _____
Dr. Randi Raizner (Initial) _____

Information regarding person or entity who can receive and use this information:

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: (_____) _____ Fax: (_____) _____

Insurance Company: _____
(Name)

Other: (Neurologist, pediatrician, school, nanny, family member, etc.)
Name: Address: Phone: Fax/Email:

_____

_____

_____

The information to be disclosed (initial any that apply):

_____ Client therapeutic process/progress
_____ Verbal/written communication between professionals
_____ Diagnosis
_____ Test, assessment or evaluation results
_____ Date of treatment
_____ Session notes
_____ Billing information
_____ **Entire record**

Other: _____

Providing Premier Pediatric Assessments and Therapy
www.carruthcenter.org | 713-935-9088
11001 Hammerly Blvd., Houston, TX 77043

Include: (*Indicate by Initialing*)
_____ Drug, alcohol or substance abuse records
_____ Mental health records (except psychotherapy notes)
_____ HIV/AIDS-related information (including HIV/AIDS test results)
_____ Genetic information (including genetic test results)

Reason for release of information:
(Choose all that apply)
□ Treatment/continuing medical care
□ Personal use
□ Billing or claims
□ Insurance
□ Legal purposes
□ School
□ Employment
□ Other *(specify)*: _____

The individual signing this form agrees and acknowledges as follows:

(i) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **Effective Time Period:** This authorization shall be in effect (1) year to date from the following date: Month: _____ Day: _____ Year: _____.

(iii) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iv) **Special Information:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

(v) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:
Patient/Legal Representative: _____ Date: _____

Printed Name of Legally Authorized Representative (if applicable): _____

If Legal Representative, relationship to Patient: _____

Witness (optional): _____ Date: _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (if applicable): _____ Date: _____

Providing Premier Pediatric Assessments and Therapy
www.carruthcenter.org | 713-935-9088
11001 Hammerly Blvd., Houston, TX 77043

THE CARRUTH CENTER
AT THE PARISH SCHOOL

THE CARRUTH CENTER
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.

EFFECTIVE August 1, 2017

This Notice of Privacy Practices (the "*Notice*") tells you about the ways we may use and disclose your personal health information ("*PHI*") and your rights and our obligations regarding the use and disclosure of your medical information. This Notice applies to The Carruth Center including its providers and employees (the "*Practice*").

I. OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of your PHI, to the extent required by state and federal law;
- Give you this Notice explaining our legal duties and privacy practices with respect to PHI about you;
- Notify affected individuals following a breach of unsecured PHI under federal law; and
- Follow the terms of the version of this Notice that is currently in effect.

II. HOW WE MAY USE AND DISCLOSE PERSONAL HEALTH INFORMATION ABOUT YOU:

The following categories describe the different reasons that we typically use and disclose PHI. These categories are intended to be general descriptions only, and not a list of every instance in which we may use or disclose your PHI. Please understand that for these categories, the law generally does not require us to get your authorization in order for us to use or disclose your PHI.

A. For Treatment: We may use and disclose PHI about you to provide you with health care treatment and related services, including coordinating and managing your health care. We may disclose PHI about you to health care providers and personnel who are providing or involved in providing health care to you (both within and outside of the Practice). For example, should your care require referral to or treatment by another provider of a specialty outside of the Practice, we may provide that provider with your PHI in order to aid the provider in his or her treatment of you.

B. For Payment: We may use and disclose PHI about you so that we or may bill and collect from you. This may also include the disclosure of PHI to obtain prior authorization for treatment and procedures from your insurance plan. For example, we may send an invoice for payment to you, and that invoice may have a code on it that describes the services that have been rendered to you.

C. For Health Care Operations: We may use and disclose PHI about you for our health care operations. These uses and disclosures are necessary to operate and manage our practice, to promote quality care, and to contact you when necessary. For example, we may need to use or disclose your PHI in order to assess the quality of care you receive or to conduct certain cost management, business management, administrative, or quality improvement activities.

D. Appointment Reminders and Health-Related Benefits and Services: We may use and disclose PHI, in order to contact you (including, for example, contacting you by phone and leaving a message on an answering machine) to provide appointment reminders and other information. We may use and disclose PHI to tell you about health-related

benefits or services that we believe may be of interest to you. We may use email to contact you about your health care invoice or payment.

E. **Business Associates:** There are some services (such as billing or legal services) that may be provided to or on behalf of our Practice through contracts with business associates. When these services are contracted, we may disclose your PHI to our business associate so that they can perform the job we have asked them to do. To protect your PHI, however, we require the business associate to appropriately safeguard your information.

F. **As Required by Law:** We will disclose PHI about you when required to do so by federal, state, or local law or regulations. This may include sharing your PHI with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

G. **Individuals Involved in Your Care or Payment for Your Care:** We may disclose PHI about you to a friend or family member who is involved in your health care, as well as to someone who helps pay for your care, but we will do so only as allowed by state or federal law (with an opportunity for you to agree or object when required under the law), or in accordance with your prior authorization.

H. **To Avert an Imminent Threat of Injury to Health or Safety:** We may use and disclose PHI about you when necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. Such disclosure would only be to medical or law enforcement personnel.

I. **Public Health Risks:** We may disclose PHI about you to public health authorities for public health activities. As a general rule, we are required by law to disclose certain types of information to public health authorities, such as the Texas Department of State Health Services. The types of information generally include information used:

- To prevent or control disease, injury, or disability (including the reporting of a particular disease or injury).
- To report births and deaths.
- To report suspected child or elderly or disabled abuse or neglect.
- To report reactions to medications or problems with medical devices and supplies.
- To notify people of recalls of products they may be using.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a child or adult has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- To provide information about certain medical devices.
- To assist in public health investigations, surveillance, or interventions.

J. **Health Oversight Activities:** We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include audits, civil, administrative, or criminal investigations and proceedings, inspections, licensure and disciplinary actions, and other activities necessary for the government to monitor the health care system, certain governmental benefit programs, certain entities subject to government regulations which relate to health information, and compliance with civil rights laws.

K. **Disaster Relief Situation:** We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your case, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can.

L. **Facility Directories:** We may use or disclose certain aspects of your PHI in order to maintain a directory of individuals in the facility. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can.

M. **Legal Matters:** If you are involved in a lawsuit or a legal dispute, we may disclose PHI about you in response to a court or administrative order, subpoena, discovery request, or other lawful process. In addition to lawsuits, there may be other legal proceedings for which we may be required or authorized to use or disclose your PHI,

such as investigations of health care providers, competency hearings on individuals, or claims over the payment of fees for medical services.

N. **Law Enforcement, National Security and Intelligence Activities:** In certain circumstances, we may disclose your PHI if we are asked to do so by law enforcement officials, or if we are required by law to do so. We may disclose your PHI to law enforcement personnel, if necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. We may disclose PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

O. **Fundraising:** We may use or disclose certain limited amounts of your PHI to send you fundraising materials. You have a right to opt out of receiving such fundraising communications. Any such fundraising materials sent to you will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

P. **Electronic Disclosures of Medical Information:** Under Texas law, we are required to provide notice to you if your PHI is subject to electronic disclosure. This Notice serves as general notice that we may disclose your PHI electronically for treatment, payment, or health care operations or as otherwise authorized or required by state or federal law.

Q. **Mental Health Information:** We will not disclose mental health records containing your identity, diagnosis, evaluation, or treatment unless authorized by law or upon your written consent.

II. YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

A. **Authorization Required: Psychotherapy Notes, Marketing, and Sale of Medical Information.** There are times we may need or want to use or disclose your PHI for reasons other than those listed above, but to do so we will need your prior authorization. In these cases, we will never use or share your information absent written authorization by you:

- Most uses and disclosures of "psychotherapy notes";
- Marketing purposes; and
- Sale of medical information.

B. **Right to Revoke Authorization:** Other uses and disclosures of your PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us with written authorization to use or disclose your PHI for such other purposes, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your PHI for the reasons covered by your written authorization. You understand that we are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided to you.

IV. YOUR RIGHTS REGARDING YOUR PERSONAL HEALTH INFORMATION:

Federal and state laws provide you with certain rights regarding the PHI we have about you. The following is a summary of those rights.

A. **Right to Inspect and Copy:** Under most circumstances, you have the right to inspect and/or copy your PHI that we have in our possession, which generally includes your medical and billing records. To inspect or copy your PHI, you must submit your request to do so in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or certain supplies associated with your request. The fee we may charge will be the amount allowed by state law.

We may also provide you with a summary of your PHI, rather than the entire record, or we can provide you with an explanation of the PHI which has been provided to you, so long as you agree to this alternative form and pay the associated fees.

If your requested PHI is maintained in an electronic format (e.g., as part of an electronic medical record, electronic billing record, or other group of records maintained by the Practice that is used to make decisions about you) we will provide you with the requested PHI in the electronic form and format requested, unless you agree to accept it in another format. If it is not readily producible in the requested electronic form and format, we will provide access in a readable electronic form and format as agreed to by the Practice and you.

In certain very limited circumstances allowed by law, we may deny your request to review or copy your PHI. We will give you any such denial in writing. If you are denied access to PHI, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will abide by the outcome of the review.

B. Right to Amend: If you feel the PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Practice. To request an amendment, your request must be in writing and submitted to the HIPAA Officer at the address listed in Section VI below. In your request, you must provide a reason as to why you want this amendment. If we accept your request, we will notify you of that in writing.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (i) was not created by us (unless you provide a reasonable basis for asserting that the person or organization that created the information is no longer available to act on the requested amendment), (ii) is not part of the information kept by the Practice, (iii) is not part of the information which you would be permitted to inspect and copy, or (iv) is accurate and complete. If we deny your request, we will notify you of that denial in writing.

C. Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your PHI. This is a list of the disclosures we have made for up to six years prior to the date of your request of your PHI, but does not include disclosures for Treatment, Payment, or Health Care Operations (as described in Sections II A, B, and C of this Notice) or disclosures made pursuant to your specific authorization (as described in Section III of this Notice), or certain other disclosures.

If we make disclosures through an electronic health records (EHR) system, you may have an additional right to an accounting of disclosures for Treatment, Payment, and Health Care Operations. Please contact the Practice's HIPAA Officer at the address set forth in Section VI below for more information regarding whether we have implemented an EHR and the effective date, if any, of any additional right to an accounting of disclosures made through an EHR for the purposes of Treatment, Payment, or Health Care Operations.

To request a list of accounting, you must submit your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

Your request must state a time period, which may not be longer than six years (or longer than three years for Treatment, Payment, and Health Care Operations disclosures made through an EHR, if applicable) and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you a reasonable fee for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

D. Right to Request Restrictions: You have the right to request a restriction or limitation on the PHI we use or disclose about you for Treatment, Payment, or Health Care Operations. You also have the right to request a restriction or limitation on the PHI we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

Except as specifically described below in this Notice, we are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide

emergency treatment. In addition, there are certain situations where we won't be able to agree to your request, such as when we are required by law to use or disclose your medical information. To request restrictions, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI of this Notice below. In your request, you must specifically tell us what information you want to limit, whether you want us to limit our use, disclosure, or both, and to whom you want the limits to apply.

As stated above, in most instances we do not have to agree to your request for restrictions on disclosures that are otherwise allowed. However, if you pay or another person (other than a health plan) pays on your behalf for an item or service in full, out of pocket, and you request that we not disclose the PHI relating solely to that item or service to a health plan for the purposes of payment or health care operations, then we will be obligated to abide by that request for restriction unless the disclosure is otherwise required by law. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

E. Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, not at work or, conversely, only at work and not at home. To request such confidential communications, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

We will not ask the reason for your request, and we will use our best efforts to accommodate all reasonable requests, but there are some requests with which we will not be able comply. Your request must specify how and where you wish to be contacted.

F. Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, you must make your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

G. Right to Breach Notification: In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your PHI has been improperly disclosed or otherwise subject to a "breach" as defined in and/or required by HIPAA and applicable state law.

V. CHANGES TO THIS NOTICE:

We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for PHI we already have about you as well, as any information we receive in the future. We will post a copy of the current notice, along with an announcement that changes have been made, as applicable, in our office. When changes have been made to the Notice, you may obtain a revised copy by sending a letter to the Practice's HIPAA Officer at the address listed in Section VI below or by asking the office receptionist for a current copy of the Notice.

VI. COMPLAINTS:

If you believe that your privacy rights as described in this Notice have been violated, you may file a complaint with the Practice at the following address or phone number:

The Carruth Center
Attn: HIPAA Officer
11001 Hammerly Blvd.
Houston, Texas 77043
(713) 935-9088

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

In addition, if you have any questions about this Notice, please contact the Practice's HIPAA Officer at the address or phone number listed above.

VII. ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS:

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

_____

_____

Patient Name: _____
(Please Print Name)

Patient Date of Birth: _____

SIGNATURES:

Patient/Legal Representative: _____Date: _____

Printed Name: _____

If Legal Representative, relationship to Patient: _____

Witness (optional): _____ Date: _____

THE CARRUTH CENTER
AT THE PARISH SCHOOL

Speech-Language Pathology Services

Schedule of Fees

• Speech-Language Consultation (60 minutes *without* a report)	$100.00
• Speech-Language Consultation (60 minutes *with* a report)	$135.00
• Speech-Language Evaluation (up to 2 hours with a report)	$400.00
• Individual Session (30 minutes)	$67.50
• Individual Session (45 minutes)	$101.25
• Individual Session (60 minutes)	$135.00
• Group Session (per hour)	$85.00
• Parent Conference (30 minutes)	$67.50