

ALLISON THERAPEUTICS, LLC

Case History Questionnaire

Patient's Name: _____ Date: _____
First Middle Last

Date of Birth: _____

Caregiver's Name _____ Relationship to Child _____

Address _____

City State Zip

Home Phone: _____ Alternate Phone: _____

Email: _____

What language(s) is/are spoken in the home? _____ Primary _____

Who lives in the home? _____

INSURANCE

Insurance Company _____ Policy # _____

Name on Policy _____ Insured's Birthdate _____

Secondary Insurance: _____ Policy # _____

REFERRAL

How did you hear about Allison Therapeutics, LLC? _____

ACADEMIC INFORMATION

School Phone: _____

Address _____

Teacher Grade

Briefly indicate how well your child functions in school _____

MEDICAL INFORMATION

Physician _____ Phone: _____

Address _____

1233 Ben Sawyer Blvd, Ste 500
Mount Pleasant, SC 29464
ph-843-697-0396
fax-803-675-0787
jenni@allisontherapeutics.com

Has your child received any other Speech-Language Pathology services? _____
With whom? _____
How long? _____

Please mark if your child has or has ever been diagnosed with any of the following:.

- | | |
|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cleft Lip |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Cleft Palate |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Hearing Impairment |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Malnutrition |
| <input type="checkbox"/> Gastro-intestinal issues | <input type="checkbox"/> Genetic Syndrome |
| <input type="checkbox"/> Brain Injury or Trauma | <input type="checkbox"/> Down Syndrome |
| <input type="checkbox"/> Tracheal malasia | <input type="checkbox"/> Pierre Robin Syndrome |
| <input type="checkbox"/> Tracheostomy | <input type="checkbox"/> Prader-Willi Syndrome |

SPEECH AND LANGUAGE INFORMATION

Speech

What percentage of your child's speech is understandable to family members? _____
to unfamiliar people? _____

Briefly describe your child's speech as you perceive the errors _____

Rate

Please mark those that apply.

- ☐ Rapid speech
- ☐ Stuttering behaviors
- ☐ Involuntary tics, Repetitive sounds
- ☐ None of the above

Language

Does your child understand more than he/she can say? _____
Does your child consistently use specific sounds to designate certain objects, people or things? _____

History

Is your child aware of your speech concerns? _____
Does he/she have concerns about his/her own speech? _____
If so, how does this affect his/her social interactions and/or academic performance? _____

FEEDING INFORMATION

Does your child demonstrate strong preferences and aversions to particular foods? _____

If so, please specify. _____

Briefly describe concerning behaviors involving feeding _____

ADDITIONAL INFORMATION

Please provide any further information you feel is relevant to your child's speech, language and feeding performance.

Please attach any files from schools or physicians that you feel are relevant to this issue.

Thank you for contacting Allison Therapeutics, LLC for your speech-language and feeding concerns.

Patient's Full Name: _____

Date of Birth: _____

Patient Signature (or signature of legal guardian): _____

Date: _____

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HIPAA AUTHORIZATION FORM
Health Insurance Portability and Accountability Act

I, _____, give permission to Allison Therapeutics, LLC to Receive and Disclose evaluation and progress reports including protected health information regarding _____ from/to:

1. Primary MD: _____
2. Insurance: _____
3. School: _____
[Name(s) of entity to receive information]

Information to be disclosed includes (check all that apply):

- ☐ Medical Records
- ☐ Treatment Records
- ☐ Diagnostic Records
- ☐ School Records
- ☐ Other: _____

This protected information is being used or disclosed for to achieve Interdisciplinary collaboration and to provide services which consider the whole child and his/her functional needs.

This authorization expires:

- ☐ Upon discharge from therapy
- ☐ Date: _____

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. You may inspect or copy the protected health information to be used or disclosed under this authorization.

Finally you may revoke this authorization in writing at any time by sending written notification to Jennifer Reidenbach at Allison Therapeutics LLC, 1233 Ben Sawyer Blvd, Suite 500, Mount Pleasant, South Carolina 29464. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

Signature of Participant or Personal
Representative / Date

Printed Name of Participant or Personal
Representative



ALLISON THERAPEUTICS, LLC

NOTICE TO PATIENTS

This is to notify you that your insurance company may not pay for outpatient speech-language pathology services. Please refer to your health insurance benefit booklet for specific information about covered services.

In the case that your insurance coverage lapses or denies payment, you will be responsible for payment of charges when services are rendered. We are happy to answer any questions that may arise.

In the case a treatment session must be canceled, it is customary that no fee will occur when 24-hour notice is provided. If this is not achieved, fees will incur.

- \$20 will be due if the patient calls the therapist and reschedules the session for a time before his/her next scheduled appointment.
- \$40 will be due if the patient does not reschedule the appointment.
- Full payment at rate of \$100/hour for the scheduled time will be due if the patient does not call to notify the therapist.

Thank you.

I have been notified and accept fee responsibility for unattended sessions and non-covered services at Allison Therapeutics, LLC.

Patient's name

Patient/Caregiver Signature

Date

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