Greater Learning, LP
April Smith, M.A., CCC
3201 Cherry Ridge, Suite C-323 San Antonio, TX 78230
(210) 349-1415 Office (210) 349-1417 Fax

Today's Date_____ Referred By: _____

PATIENT INFORMATION:

Name:_____Birthdate:_____Age:_____
Sex: Male:_____Female:_____
Address:_____
City:_____State:_____Zip:_____
Home Phone: _____ Patient Cell Phone: _____
School:_____Grade:_____
Principal:_____Teacher:_____
Sibling Names:_____Age:_____
_____Age:_____

PERSON RESPONSIBLE FOR BILLING: (FATHER/MOTHER, CIRCLE ONE)

Name:_____Birthdate:_____Age:_____
Sex: Male: _____ Female:_____
Address:_____
City:_____State:_____Zip:_____
Home Phone: _____Work Phone:_____Cell Phone: _____
Email:_____
Employer: _____
Occupation: _____
Business Address:_____
City: _____ State: _____ Zip:_____

FATHER/ MOTHER: (CIRCLE ONE)

Name:_____Birthdate:_____Age:_____
Sex: Male: _____ Female:_____
Address:_____
City:_____State:_____Zip:_____
Home Phone: _____Work Phone:_____Cell Phone: _____
Email:_____
Employer: _____
Occupation: _____
Business Address:_____
City: _____ State: _____ Zip:_____

Name:_____ Date: _____

I. STATEMENT OF THE PROBLEM:

Describe the problem:

_____

_____

_____

_____

II. FAMILY HISTORY:

Are there any family members who have problems similar to your child's when they were young?_____ If yes, please list relationship and nature of their problem._____

_____

_____

Have there been any major changes within the family during the last three years? (for example: job changes, moves, births, deaths, illnesses, marriages, separations or divorces). _____

_____

_____

III. PREGNANCY AND BIRTH HISTORY:

Did the mother experience any difficulties, unusual illness, condition or accident during this pregnancy? _____ If so, describe:_____

_____

Where there any complications during the delivery such as cesarean, extremely long labor, or use of instrument? _____ If so describe: _____

_____

Child's Birth weight: _____

IV. DEVELOPMENTAL HISTORY:

At what age did the following occur:

Sat alone unsupported: _____Crawled:_____

Walked Alone: _____

Maintained bowel and bladder control while:

Awake: _____Asleep:_____

Began Speaking? _____Use two word sentences?_____

Name:_____ Date: _____

Does the child understand what is said to them?_____

How well is the child understood by parents?_____

By others? _____

What was your child's first language? _____

What is your child's dominate or primary language now?_____

Did/Does your child have any feeding problems? (gagging, choking, reflux)

_____

Was your child bottle/ breast fed? _____

Until what age? _____

Did/Does your child take a pacifier/suck their thumb?_____

Until what age? _____

What age did your child begin self-feeding?_____

Use Utensils? _____

Is your child a picky eater? _____

Have food sensitivities?_____

Does your child seem awkward or uncoordinated? _____

Did your child ever have trouble sleeping? _____

PHYSICAL/MEDICAL HISTORY:

YES NO

☐ ☐ Has your child ever had seizures (convulsions), encephalitis, meningitis, whooping cough or other serious illness? If yes, please explain and approximate at what age.

_____

☐ ☐ Does your child have a history of ear infections? If yes, please explain.

_____

☐ ☐ Does your child have any physical abnormalities? If yes, please explain.

_____

☐ ☐ Has your child ever been unconscious at any time? If yes, please explain.

_____

☐ ☐ Has your child ever been hospitalized and at what age? If yes, please explain. _____

☐ ☐ Has your child ever had surgery and at what age? If yes, please explain.

_____

Name:_____ Date: _____

☐☐ Has your child ever been seriously injured or in an auto accident and at what age? If yes, please explain.

_____

_____

☐☐ Has your child ever taken medication for a long period of time? If yes, please explain. _____

☐☐ Has your child ever had a drug or alcohol problem? If yes, please explain.

_____

☐☐ Is your child currently in good health? If no, please explain.

_____

☐☐ Does your child have hearing problems? If yes, please explain.

_____

☐☐ Does your child have asthma or allergies? If yes, please explain._____

☐☐ Is your child currently taking any medication? If yes, please explain._____

☐☐ Is your child under the care of a physician for medical problems? If yes, please explain. _____

A. Has your child had a speech examination prior to this time?_____

If so, when and where? _____

What were the results? _____

B. Has your child had any other evaluations or are they currently receiving services?

(PT, OT, ABA) _____

What were the results? _____

C. Has your child had a hearing test prior to this time? _____. What were the results?

_____

D. Has your child had a neurological examination prior to this time?_____. If so, where and when?_____

E. Has your child had a psychological examination prior to this time?_____ If so, where and when?_____ What were the results?_____

F. Has your child had an eye examination prior to this time?_____ If so, where and when?_____

What were the results?_____

G. Has your child had a recent medical examination?_____

If so, where and when:_____

What were the results?_____

Name:_____ Date: _____

V. DAILY BEHAVIOR

A. Has your child been harder to manage then other children? _____ If so, describe:_____

_____

B. Describe any unusual behavior:_____

C. Describe your child's interest: _____

D. What methods of discipline are used with your child at home? (For example, restriction, spanking, extra chores, early bedtime, rewards for good behavior). What is your child's reaction to discipline?

_____

_____

_____

VII. EDUCATION HISTORY:

A. Has your child repeated any grades? _____ If so, which

_____

B. What are your child's academic strengths and weaknesses?

_____

C. Has your child ever had special help through the school? _____If so, describe: _____

D. Has your child ever been suspended from school? Yes☐ No☐. If yes, when and for what reason? _____

_____

E. How does your child feel about school? _____

F. Is there anything additional you would like to tell us about your child?

_____

_____

_____

GREATER LEARNING, LP
3201 Cherry Ridge Street # C-323
San Antonio, Texas 78230
(210) 349-1415

Food and Allergy Form

During treatment sessions we often utilize foods to support our interventions. We would like to be sensitive to your child's health and safety. Please note any foods your child is not allowed to have or restrictions due to allergies.

Patient Name _____
First Last

My child _____ may not have the following foods: _____

_____

_____

_____

My child _____ is allergic to the following foods: _____

_____

_____

_____

Signature _____ Date ____/____/____

_____
Parent/Guardian Printed Name

_____
Relationship to Patient

_____
Primary Care Physician Phone Number

Greater Learning, LP
3201 Cherry Ridge Drive #C-323
San Antonio, TX 78230
Phone: (210) 349-1415
Fax: (210) 349-1417

CHILD/ADOLECENT CONSENT FORM

CONSENT FOR TREATMENT

I ,_____, acting on behalf of _____ give permission to Greater Learning, LP, to provide evaluations, treatment, and consultative services to the above mentioned patient. I understand treatment will consist of services outlined in the plan of care. I further understand that these services and treatment options will be explained at the initial evaluation and each time the plan of care is updated.

MEDICAL RECORDS RELEASE

I, the undersigned parent/guardian, authorize Greater Learning, LP to release/request professionally necessary information to the individuals, institutions, and agencies listed below.

_____

_____

_____

I understand Greater Learning, LP will not share information regarding the above mentioned patient with any individuals not listed on this form and all medical records, treatment notes, and other individually identifiable health information will be kept properly confidential.

FINANCIAL RESPONSIBILITY

I understand I am financially responsible for all charges for medical services rendered on my behalf, including those not paid or reimbursed by my insurance company. I am aware my insurance carrier may deny payment for the services rendered. Therefore, if payment is denied, I agree to be personally liable and fully responsible for such payment.

Insurance benefits are checked at initial intake to determine if there are any exclusions, deductibles, pre-existing clauses, or additional requirements on the policy when coverage for therapy is available. The information shared with me by the office is a courtesy and not a guarantee of coverage.

Patient Name: _____ **Date:** _____

CHARGES FOR SERVICES RENDERED

I understand all co-payments, deductibles, or charges for non-covered services will be collected at the time of check-in. Accepted forms of payment at the Cherry Ridge office are: cash, check, Visa, MasterCard, and Debit Card. If seen at another location it is recommended to have a credit card on file so payment can be made conveniently and collected the day of or after each visit.

ATTENDANCE AND CANCELLATION POLICY

Greater Learning strives to provide each patient with the highest quality of care while accommodating your schedule. We reserve time allotments for each patient; therefore, keeping your appointments on a consistent basis is a key factor in making progress with you/your child's therapy goals and care plan.

I understand that cancellations made less than 24 hours in advance are billed a fee of $50, except for emergency situations or illness. If we do not receive advance notice of a cancellation, it will be considered a "no show-no call" episode. You will be charged a fee of $50. I understand that a charge for a missed session will not be billed to my insurance and is my responsibility.

It is our policy that if a patient has 2 "no show-no call" episodes or 3 non-emergency cancellations within a 3 month period, that their treatment program may be terminated

A 24 hour answering service is available and will forward a message if calling after normal business hours.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Greater Learning, LP, has provided me with a Notice of Privacy Practices. I have read and understand the rules and regulations, and my rights as a patient under the Health Insurance Portability and Accountability Act (HIPAA).

Signature of Parent/Guardian: _____ **Date:** _____

Signature of Office Personnel: _____ **Date:** _____

Greater Learning, LP
3201 Cherry Ridge Street #C-323
San Antonio, TX 78230
Phone: (210) 349-1415
Fax: (210) 349-1417

Electronic Communications and Social Media Policy

This document outlines the policies of Greater Learning, LP as they relate to electronic communication and the use of social media.

Email:

While we recognize that email has become an alternate method of communication we want you to understand the risk involved in communicating sensitive Protected Health Information (PHI) via email/internet. Emails received from Greater learning, LP may or may not be encrypted. Also note emails are retained in the logs of your and our internet service providers. While Greater Learning, LP maintains a Business Agreement in compliance with HIPPA with our internet service provider, we do not maintain one with your internet service provider. While it is unlikely someone will be looking at these logs, they are in theory, available to be read by system administrator(s) of the internet service provider. You should also know that any emails received from you and any responses sent to you become part of your/the patient's medical record.

Text Messages:

Text messaging, like email, has become a convenient method of communication. If you choose to utilize text messaging with your therapist we request these be limited specifically to appointment times or scheduling. Text messaging is not appropriate to discuss patient care/progress and should be avoided. Please note therapists will not communicate patient information of this nature via text messaging. Text messages, just like other forms of communication regarding patient care, become part of the patient's medical record.

Facebook:

Greater Learning, LP maintains a Facebook Page for patients, family members and the community to access information. We encourage you to "Like" Greater Learning as we often post information and resources you may find helpful.

Greater Learning therapists will not accept friend requests from current or former clients on social network sites (Facebook, LinkedIn). Adding patients as friends or contacts on these sites can compromise your confidentiality and our respective privacy.

Conclusion:

Greater Learning, LP appreciates the opportunity to continue to provide services to you, and recognizes the importance of maintaining quality service and not compromising our respective privacy. I am available if you have any questions or concerns about any of these policies and/or procedures and I may be reached at the office at 210-349-1415.

April Smith, M.A. CCC-SLP
Managing Partner

Email Acknowledgement and Consent Form

The purpose of this form is to obtain your consent to communicate with you by email for appointment reminders and other healthcare communications containing protected healthcare information (PHI).

Patients in our practice may be contacted via e-mail to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide health reminders or information.

Greater Learning offers patients the opportunity to communicate by email. Transmitting patient information by email has possible risks that should be considered before granting consent to use email for these purposes. Email communication may not always be encrypted or secure. There may be a possibility that the information you include in an email can be intercepted, altered, forwarded, or used without authorization or detection.

Greater Learning will use reasonable means to protect the security and confidentiality of email information sent and received. However, Greater Learning cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

Patient's Acknowledgement and Agreement

☐ I acknowledge the receipt of Greater Learning's Electronic Communication and Social Media Policy. I agree and consent that Greater Learning may communicate with me by email regarding appointment reminders and other healthcare communications containing PHI. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between Greater Learning and/or its employees and me, and consent to the conditions outlined herein. Any questions that I may have had were answered.

☐ I DO NOT consent to the use of email in communicating with me regarding appointment reminders and other healthcare communications containing PHI.

Patient Name:_____ Date of Birth:_____

Patient/Parent/Guardian Signature:_____

Printed Name:_____ Date:_____

Preferred Email Address(es):_____

_____

GREATER LEARNING, LP
3201 Cherry Ridge, Ste. C-323
San Antonio, Texas 78230
(210)349-1415

ATTENDANCE/CANCELLATION POLICY AGREEMENT

Name of patient: _____
(Please print)

The following is a description of the Greater Learning attendance/cancellation policies. Please read and indicate your agreement to abide by these policies by initialing and signing where indicated.

Scheduling Policies

1. **Cancellations**: I understand that at least 24 hours notice is required for cancellation of a scheduled therapy or evaluation session, unless it is due to illness, a family or personal emergency, or inclement weather. Otherwise, I understand that for sessions canceled with less than 24-hours notice or for failure to attend a session I may be charged $50 the first time and thereafter the full fee for the session unless a "make-up" can be scheduled within 2 weeks. We require make-up sessions in order to ensure optimal progress.

   Cancellations will only be accepted by phone. E-mail or text message will not be considered valid. We continue to maintain a 24 hour answering service to accommodate our patients.

   If my insurance company is paying for treatment they cannot be billed for a missed session; therefore I understand I will be billed for the cost of the session at the rate reimbursed by my insurance company.

   I understand that if sessions are canceled with more than 24 hours notice, I will not be charged a cancellation or missed appointment fee. **However following repeated cancellations and failure to keep appointments #2 below will apply.**

2. **Repeat Cancellations or "No-Shows":** If a patient cancels or fails to attend 3 or more appointments within a 3 month period, the patient will forfeit regular recurring sessions for 3 months, and will have to schedule appointments one week at a time during that period. The count of 3 cancelled or missed appointments can be offset by scheduling a make-up session within 2 weeks.

3. I understand that when a therapist is ill, Greater Learning will make every effort to provide therapy, but recognize they may not be able to provide a substitute therapist. When our therapist is on a scheduled vacation we will give at least 2 weeks notice and every effort will be made to provide a substitute therapist.

Signature: _____

Date: _____

Patient Name: _____ Date: _____

GREATER LEARNING, LP

3201 Cherry Ridge, Ste. C-323
San Antonio, TX, 78230
(210) 349-1415

Telephone and Electronic Communications Consent Forms

I understand my therapist may from time to time update me on mine or my child's progress via email.

I also understand, and agree, to billing for additional time spent responding to my email's and phone calls.

I understand these services are not billable to my insurance and accept fees billed to me directly.

Policy on Video Recording

We invite you to record activities in our sessions, when appropriate, that will support skills within you child's daily activities.

We do however ask that parents respect the privacy of the therapy environment. Nothing recorded within our clinics can be used for anything other than home interventions.

Please note all recordings and pictures require permission from the treating therapist.

_____
Printed Name

_____
Signature of Parent/Guardian

_____
Date

GREATER LEARNING, LP

3201 CHERRY RIDGE, STE C-323
SAN ANTONIO, TX 78230
(210) 349-1415 Office (210) 349-1417

Privacy Officer: April Smith, M.A., CCC **Effective Date: April 1, 2003**

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.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practice. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who Will Follow This Notice. Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You. The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of use or disclosures. Not every possible use or disclosure in a category is related.

For Treatment. Treatment involves such activities as performing an assessment, developing a treatment plan for you or providing group or individual therapy. Example: The attending therapist or supervisor will record information in your record regarding your diagnosis and condition, what types of treatment you are to receive and progress on said goals. All staff involved in your treatment are able to read these entries, and to make entries of their own that other staff may read.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization. Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing , at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we provided you.

Your Individual Rights Regarding Your Medical Information
Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the privacy officer of this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that the medical information 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. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. 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 the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to an Accounting of Non-Standard Disclosures. You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and my not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12 month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

Changes to This Notice. We reserve the right to change this Notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date in the upper right corner of the first page.

Submit Patient Paperwork