engage
therapy center

10263 Chicago Drive,
Zeeland, MI 49464

SPEECH AND LANGUAGE CASE HISTORY FORM

Child's Name: ______________________ | □ Male □ Female | Date of Birth: ______________
Form Completed by (name): ____
Relationship to child: ______________________ Today's Date: ______________________

FAMILY INFORMATION

Parent/Guardian Name: ____
Address: ____
Phone: ______________________ E-mail: ______________________
Preferred method of contact: □ Phone □ Text □ E-mail

Parent/Guardian Name: ____
Check here if contact information below is same as above: □
Address: ____
Phone: ______________________ E-mail: ______________________
Preferred method of contact: □ Phone □ Text □ E-mail

Sibling Name: ______________________________________ Age: __________
Sibling Name: ______________________________________ Age: __________
Sibling Name: ______________________________________ Age: __________
*Please list any additional siblings in "Additional Comments" section

Have any family members had any speech, language, hearing problems, or learning difficulties? □ No □ Yes
Describe (If Applicable): ____
____

Who currently lives in the child's home? ____
____
____

Child's primary caregiver: ____

Any current or anticipated custody changes? (i.e. adoption, divorce, custody agreements) □ Yes □ No
If yes, please describe: ____
____
____
____

Language(s) spoken in the home (check all that apply): □ English | □ Spanish | □ Other: ______________

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SPEECH AND LANGUAGE INFORMATION

Describe any concerns you may have regarding your child's speech (ability to speak clearly with proper sound production).

Describe any concerns you may have regarding your child's expressive language (ability to form thoughts into words, sentences, and narratives)

Describe any concerns you may have regarding your child's receptive language (ability to understand what is said to him/her).

Is your child aware of, or frustrated by, any speech/language difficulties?

SPEECH AND LANGUAGE HISTORY

Please provide the approximate age at which your child acquired the following skills: Babbling:______________
Used first words: ______________ | Put 2-3 words together:__________ | Understood directions: ______________

How does your child usually communicate (check all that apply)?
□ Gestures □ Single words □ Short phrases □ Sentences □ AAC □ Other: __________________

In what situations does the child have more difficulty communicating?
□ At Home □ At Daycare/School □ With Friends □ Everywhere □ Other: __________________

Approximately how much of your child's speech do you understand? (circle)
< 10% 25% 50% 75% 90% - 100%

Approximately how much of your child's speech do those less familiar with the child understand? (circle)
< 10% 25% 50% 75% 90% - 100%

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MEDICAL HISTORY

Describe the mother's health during pregnancy: □ Good □ Fair □ Poor

Were there any unusual conditions or problems during the pregnancy or birth? □ Yes | □ No
If yes, please describe: ____

____

Was the pregnancy full term? □ Yes | □ No | If no, how early or late? ____________________
General birth condition: ______________________ Birth weight: ____________________

Does your child have any medically diagnosed illness or conditions? □ Yes | □ No
Explain (if applicable): ____

____

Is your child taking any medications? □ Yes | □ No | If yes, please list: ____________________

____

Has your child experienced any of the following? □ Frequent Colds |□ Seizures |□ Snoring |□ Mouth Breathing
□ Sleeping Problems |□ Frequent Ear Infections |□ Feeding Problems|□ Other: ____________________

Has your child had any surgeries, accidents or hospitalizations? □ Yes | □ No | If yes, explain: __________

____

Has your child's hearing been tested? □Yes □ No
Location of testing (if applicable) ______________________ Date Completed: __________
Results of the hearing test: □ Hearing within normal limits | □ Hearing loss | □ Further testing required

Has your child had any of the following evaluations or assessments?

□Psychological	□Physical Therapy	□ Neurological
□Occupational Therapy	□Developmental	□Vision

What were the results? ____

____

Is there anything else we should know about your child's medical history? □ Yes | □ No | If yes, explain: ______

____

____

ADDITIONAL INFORMATION

How does your child interact with others (e.g., friendly, shy, cooperative, etc.)?

Do you have any concerns about your child's behavior? If so, please describe:

What is your child's most significant difficulty at home?

Does your child attend school or daycare? ◻ Yes ◻ No

If yes, please provide name of school/daycare and grade: ____

What is your child's most significant difficulty at school/daycare (if applicable)?

What do you see as your child's strengths?

What does your child enjoy playing with or enjoy doing?

Additional comments:

CYW Adverse Childhood Experiences Questionnaire (ACE-Q) Child

To be completed by Parent/Caregiver

Today's Date: ___________________________________

Child's Name: ____ *Date of birth:* ____________________________________

Your Name: ____ *Relationship to Child:* _____________________________

Many children experience stressful life events that can affect their health and wellbeing. The results from this questionnaire will assist your child's doctor in assessing their health and determining guidance. *Please read the statements below. Count the number of statements that apply to your child and write the total number in the box provided.*

Please DO NOT mark or indicate which specific statements apply to your child.

1) Of the statements in Section 1, HOW MANY apply to your child? Write the total number in the box.

Section 1. *At any point since your child was born…*

- Your child's parents or guardians were separated or divorced
- Your child lived with a household member who served time in jail or prison
- Your child lived with a household member who was depressed, mentally ill or attempted suicide
- Your child saw or heard household members hurt or threaten to hurt each other
- A household member swore at, insulted, humiliated, or put down your child in a way that scared your child OR a household member acted in a way that made your child afraid that s/he might be physically hurt
- Someone touched your child's private parts or asked your child to touch their private parts in a sexual way
- More than once, your child went without food, clothing, a place to live, or had no one to protect her/him
- Someone pushed, grabbed, slapped or threw something at your child OR your child was hit so hard that your child was injured or had marks
- Your child lived with someone who had a problem with drinking or using drugs
- Your child often felt unsupported, unloved and/or unprotected

2) Of the statements in Section 2, HOW MANY apply to your child? Write the total number in the box.

Section 2. *At any point since your child was born…*

- Your child was in foster care
- Your child experienced harassment or bullying at school
- Your child lived with a parent or guardian who died
- Your child was separated from her/his primary caregiver through deportation or immigration
- Your child had a serious medical procedure or life threatening illness
- Your child often saw or heard violence in the neighborhood or in her/his school neighborhood
- Your child was often treated badly because of race, sexual orientation, place of birth, disability or religion

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Financial Policy and Fee Agreement

Please review our financial policy and fee agreement, which describes our schedule of fees for services, policies regarding charges not covered by insurance, and additional fees. Please be sure that you understand the financial agreements regarding insurance reimbursement, methods of payment, and dues regarding cancelations, missed appointments, and past due accounts. If you have any questions or concerns about your individual policy and its coverage, please speak directly with your provider prior to signing this agreement.

Payment is expected at time of service or within one week of received invoice.

Evaluations - $150
55-minute treatment sessions -$125
30-minute treatment sessions (pre-approval required) - $75

Additional Fees

Missed appointments or cancellations without a 24-hour notice may be assessed $50
Non-sufficient funds check - $20
Past due accounts -over 30 days $25 per month
In addition, clients who accumulate excessive cancellations or missed appointments may lose preferred time slots, and in extreme cases may be removed from the schedule.

Insurance Reimbursement

Engage Therapy Center accepts and process payments through a variety of insurance providers. Currently, we work with Blue Cross Blue Shield, Anthem, Priority Health, and Cigna. Coverage is based on diagnosis, procedure codes, referring provider, and insurance plan. It is recommended that individuals contact their individual providers to fully understand their benefits, including deductibles, copays, exclusions, and allowed number of therapy visits. As insurance is a contract between you and your insurance company, Engage Therapy is not liable for gaps in coverage, lack of coverage, or other insurance denials or disputes.

Obligation of payment is understood not to be dependent on the client receiving third party reimbursement from outside insurance coverage. We support and encourage our clients to pursue the maximum amount of financial reimbursement from third party payers, such a as health insurance agencies. Ultimately, it is the client's responsibility to submit and secure coverage that falls outside of Engage's partnered insurance companies. Private pay documentation differs from standard documentation; it is necessary to alert your therapist before the evaluation if you will be pursuing third party reimbursement.

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Insurance Coverage for Services
I have read and accept Engage Therapy's financial policy and I agree to (1) allow Engage Therapy Center to bill my insurance directly for services provided; (2) give Engage Therapy Center permission to release information about me that the insurance company may require in order to process payment; (3) assist with the claims process as required by Engage Therapy Center or my insurance provider. I understand that if my insurance plan requires a deductible amount prior to coverage, I will be responsible for the full session fee until the required deductible amount has been met. I will notify Engage Therapy Center if my insurance plan/coverage changes.

Insurance Information
Name of Primary Provider:____
Name of Practice:____
Address of Practice:____
Phone Number and Fax: (P)______________________(F)__________________________

Primary Insurance:____
Insurance policy holder:_________________________DOB__________________________
Relationship to client: ____

Address and contact information if different than client's primary residence:
Address:____
City/State/Zip:____
Phone: (H)_____________________(W)__________________(C)____________________

Patient Name (printed) ____

Patient/Guardian signature____

or

Private/Self-payment for Services
I have read and accept Engage Therapy's financial policy and I agree that I will self-pay for services at Engage Therapy Center. I agree to the fee schedule outlined in this document. I understand that payment for services is due at the time services are provided.

Patient Name (printed) ____

Patient/Guardian signature____

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Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Engage Therapy Center to use and disclose protected health information (PHI) to carry out treatment, payment and health care operations, and communicate to other health care providers and schools.

The Notice of Privacy Practices provided by Engage Therapy Center more fully describes such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this contract. I acknowledge that this release is voluntary and may be voided or edited at any time. I have the right to request that Engage Therapy Center restrict how it uses or discloses PHI.

With this consent, Engage Therapy Center may call my home or alternate location and leave a message regarding appointments or insurance/payment questions.

With this consent, Engage Therapy Center may mail any items that assist the plan of care, such as appointment reminders and patient statements as long as they are marked "Personal and Confidential." Additionally, Engage Therapy Center may email me information, such as appointment reminders and patient statements.

Client's name: ____
Printed name of legal guardian: ____
Signature of legal guardian: ____
Date: ____

By signing this consent, I give permission to relatives and adults bringing my child to his/her appointment to receive information about the treatment session.
These individuals are not to receive information:_________________________________
____

Specific providers I would like Engage Therapy Center to release information to:
Name of provider: ____
Facility:____
Phone:____

Name of provider: ____
Facility:____
Phone:____

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Photography and Recording Consent

I agree to photos/videos being taken for clinician use. They will be used for the purpose of evaluation, planning, and mentoring. The materials will only be viewed by Engage Therapy therapists and fieldwork students.

I agree to photos/videos being used for promotional materials for Engage Therapy Center. This may include social media, flyers, or brochures. I will be shown materials for approval before publication.

Signature of client or legal guardian____