



The Treatment and Learning Centers
TLC

a family of services where caring comes first

2092 Gaither Rd., Suite 100
Rockville, Maryland 20850
301.424.5200
Fax 301.424.8063
TTY 301.424.5203
www.ttlc.org

ADULT CASE HISTORY FORM: TESTING AND TUTORING SERVICES

Client Information

Name			
Date of Birth			Sex <input type="checkbox"/> M <input type="checkbox"/> F
Home Address	_____		
	Street	Apartment	

	City	State	Zip Code
Phone Number	Home	Work	Cell
	Emergency Contact Name		Phone

Who referred Client to TLC?

Name	
Relationship to Client	
Reason for Referral	
Previous services by any TLC department?	

Please List all People Residing in Client's Home

Name	Relationship	Age

Significant Family Medical History

[e.g., Speech-Language, Hearing, Sensory/Motor or Learning Disability; impaired attention; anxiety / depression; other disease or condition]

Name	Relationship	Diagnosis

A Private Non-Profit Agency Enabling Children and Adults to Develop their Full Potential

The Outcomes Service • The Family Hearing Center • The Katherine Thomas School
The Outpatient Services • The Testing and Tutoring Service • Camp Littlefoot

Social/Emotional/Educational History

Chief concern				
Date of onset				
Past medications related to chief concern (name/dosage)?				
Does client attend school? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, what school?			If no, planning to apply to school? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Year in school?			School applying to?	
Course of Study?			IEP/504 Plan during primary education? <input type="checkbox"/> Yes <input type="checkbox"/> No Grade of IEP / 504 Plan initiation?	
Current Accommodations / Interventions	YES	NO	Date	Additional Information
Books on Tape				
Copies of teacher notes				
Extra time				
Preferential seating				
Small Group Instruction				
Tests read to student				
Use of Calculator				
Use of Computer				
Writing in test booklet				
Other				
Other				
Previous Interventions	YES	NO	Date	Additional Information
Special Education Services				
Resource Assistance				
Tutoring				
Other				
Academic Areas of Concern	YES	NO	Please describe your concerns	
Math				
Organization / Time Management				
Reading				
Written Language / Writing				
Other				
Other				

Medical History

Hearing	YES	NO	N/A	Additional Information
History of hearing loss?				
Does client use a hearing aid?				Type of HA:
Please provide information regarding client's most recent hearing test.	Date:			Results:
Medications				
Please complete this section if client takes prescription or over-the-counter medication regularly. Continue on a separate page if more space is needed.	Dose	How Often	Reason Taken	
Medication:				
Medication:				
Medication:				
Medication:				
Medication:				
Diseases or Conditions				
Please provide information regarding history of diseases or conditions.	Age / Onset	Describe Treatment and / or Complications		
Allergies (i.e., food, insect bites, latex, pollen, medication, etc.)				
Anxiety / depression				
History of ear infections				
History of chronic upper respiratory infection				
History of learning difficulty				
History of problems with attention				
History of spasms, convulsions, or seizures				
Blackouts				
Cancer				
Diabetes				
Dizziness or vertigo				
Facial numbness				
Head injury				
Heart disease				
High blood pressure				
High fever [greater than 104°]				
Kidney disease				
Measles				
Meningitis				
Mumps				
Neurofibromatosis				
Scarlet fever				
Sinusitis				
Stroke				
Tinnitus [head noise]				
Vision [eye sight]				
Wears corrective lenses for vision				

Injuries and / or Surgeries				
Please provide information regarding any injury, surgery, or hospitalization.	Age	Describe Treatment and / or Complications		
Previous Evaluations / Interventions				
Please provide information regarding any previous evaluations or therapy	YES	NO	Date	Please include information regarding findings / diagnosis, and provide a copy of relevant reports.
Counseling				
Educational Achievement				
Educational / Psychological Testing				
Occupational Therapy				
Occupational Therapy Evaluation				
Physical Therapy				
Physical Therapy Evaluation				
Psychological Testing				
Speech Language Evaluation				
Speech Language Therapy				
Vocational Counseling				
Vocational Evaluation				
Other Information related to Medical History				
Other information you would like us to know about client's medical history:				

Birth and Developmental History

Birth History	Is there a history of birth complications (e.g., premature birth, delivery complications)?
Developmental History	Is there a history of delays in development (e.g., late talker, late walker)?

Employment History

Occupation	
Employer	
Describe the type of work client is / was doing in current or most recent occupation.	

Educational History

Circle Highest Grade Completed	1 2 3 4 5 6 7 8 9 10 11 12
Post- High School Education	<input type="checkbox"/> Some College <input type="checkbox"/> College Graduate <input type="checkbox"/> Technical School <input type="checkbox"/> Advanced Degree: <input type="checkbox"/> Other:

Language History

Client's Primary Language	
Other Language Exposure	
Age(s) at which other Language(s) were Introduced	
Where are other languages spoken [e.g., home, workplace]?	
Client is able to	<input type="checkbox"/> Speak _____ <input type="checkbox"/> Understand _____ <input type="checkbox"/> Write _____ <input type="checkbox"/> Speak _____ <input type="checkbox"/> Understand _____ <input type="checkbox"/> Write _____

Additional information

Other information you would like us to know about the client:

Primary Care Physician

Name	Address	Phone
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Person Completing this Form	
Relationship to the Patient	

Signature: _____

Date: _____

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**Informed Consent and Authorization
for Services
Authorization to Use, Obtain, and / or Disclose
Protected Health Information**

Consumer Name: _____ **Birth Date:** _____

Consent for Services

I hereby authorize, consent, and direct TLC - The Treatment and Learning Centers, or its agents, officers, employees, and representatives to use procedures, methods, and materials that it deems prudent, reasonable, and appropriate to provide the requested services indicated below.

Authorization to Use, Obtain and / or Disclose Protected Health Information

I authorize my TLC professional and / or administrative staff to Use, Obtain, and / or Disclose the following protected health information.

Select the Service to be provided and / or the Protected Health Information to be used, obtained and/or disclosed (check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Audiology | <input type="checkbox"/> Medical | <input type="checkbox"/> Psychological |
| <input type="checkbox"/> Occupational/Physical Therapy | <input type="checkbox"/> Tutoring/Coaching | <input type="checkbox"/> Other: (describe) _____ |
| <input type="checkbox"/> Speech-Language Therapy | <input type="checkbox"/> Educational | |

Type of Information (check all that apply)

I further authorize TLC to use, obtain and / or disclose Protected Health Information in the following form(s):

<input type="checkbox"/> Written	<input type="checkbox"/> Verbal Exchange	<input type="checkbox"/> Video / Audio Records	<input type="checkbox"/> Text Message	<input type="checkbox"/> Other:
<input type="checkbox"/> Fax	<input type="checkbox"/> Voice Mail	Email Yes <input type="checkbox"/> No <input type="checkbox"/> (see page 2 if you checked Yes)		
		Email: _____		

I authorize TLC to exchange information with the following:

NAME	FULL ADDRESS [Include PHONE, if applicable]
Self/Parent <i>[you must be listed if you want a copy of reports]:</i>	
Physician:	
School or Funding Agency:	
Other:	

TURN OVER, PLEASE



This protected health information is being used or disclosed at your request for follow-up by participating professionals, and / or for insurance / reimbursement purposes, and research. (If used for research, no identifying information will be released.)

I hereby release TLC, its agents, officers, employees, and representatives from legal responsibility or liability for services provided or information released pursuant to this Authorization.

NOTE REGARDING INSURANCE: TLC is not a participating provider with any HMO, PPO, or POS, or any other INSURANCE plan except for the following:

- (1) CIGNA (**occupational therapy, physical therapy, speech therapy, and audiology**)
- (2) United Healthcare (**audiology only**)
- (3) Medicare (**audiology only**).

I authorize TLC to submit claims for plan-eligible services to my insurance carrier; TLC will submit claims to the listed plans only. I understand that I will be required to pay copayments, amounts applied to deductibles, and any charges not paid in accordance with the benefits of the insurance plan in effect at the time services are rendered. In the event of nonpayment of submitted claims, I agree to pay the full billed charges for all services rendered.

I understand that I have the right to revoke this authorization at any time by sending written notification to

**Director of Administrative Services, TLC
2092 Gaither Road, Suite 100
Rockville, MD 20850**

Unless revoked in writing, this authorization shall be in force and effect for 1 year from the date of this document, at which time this authorization to use and / or disclose this protected health information will expire.

ACKNOWLEDGEMENTS

EMAIL CONSENT NOTICE (If you checked Yes to email on page 1)

Your signature below is your request to communicate personally identifiable information concerning your / your child's services by e-mail without the use of encryption. Sending personally identifiable information by e-mail has a number of risks that you should be aware of prior to giving your permission. These risks include, but are not limited to, the following:

- E-mail can be forwarded and stored in electronic and paper format easily without prior knowledge of the Client or other responsible party.
- E-mail senders can misaddress an e-mail and personally identifiable information can be sent to incorrect recipients by mistake.
- E-mail sent over the Internet without encryption is not secure and can be intercepted by unknown third parties.
- E-mail content can be changed without the knowledge of the sender or receiver.
- Backup copies of e-mail may still exist even after the sender and receiver have deleted the messages.
- Employers and online service providers have a right to check e-mail sent through their systems.
- E-mail can contain harmful viruses and other programs.

Acknowledgement and Agreement

I acknowledge that I have read and understand the items above that describe the inherent risks of using e-mail to communicate personally identifiable information. Nevertheless, I authorize TLC – The Treatment and Learning Centers and members of my treatment team to communicate with me at my e-mail address concerning services provided to me / my child, including but not limited to, communication regarding service delivery, my / his / her progress towards goals, and any other related matters. I

understand that use of e-mail without encryption presents the risks noted above and may result in an unintended disclosure of such information.

I further agree that I will not use e-mail to communicate with TLC, and will use other means of communication (e.g., telephone, in-person visit, etc.) for the following:

- Emergencies or other time-sensitive issues that require immediate action
- Inquiries that deal with sensitive information
- Situations in which TLC does not / is unable to respond to an e-mail communication (e.g., offices closed, power outage)

I understand that TLC will make a reasonable attempt to return all e-mail messages received within two (2) business days; however, if I do not receive a response by the close of business on the second business day following my e-mail communication, I agree to use other means of communication to contact TLC. I further understand that e-mail communications with TLC is offered as a convenience to me, and agree to not hold TLC responsible for any expense, loss, or damage caused by or resulting from the following:

- A delay in TLC’s response, or any damage to me / the Client resulting from such delay, including, but not limited to the following: therapist absence, therapist inability to respond, technical failures attributable to TLC’s internet service provider, power outages, failure of TLC’s electronic messaging software, failure by TLC or me / the Client to properly address e-mail messages, failure of TLC’s computers / computer network, or faulty telephone / cable data transmission
- Any interception of my or TLC’s e-mail communications by a third party
- My failure to comply with the guidelines regarding use of e-mail communications set forth above

HIPAA PRIVACY NOTICE

By signing this form, you acknowledge that The Treatment & Learning Centers / KTS has provided you access to a copy of its HIPAA Privacy Notice, which explains how your health information will be handled in various situations. By law, we are required to have you sign this acknowledgement on your first date of service with us.

The Practice has provided me access to its Privacy Notice. I understand I may request a copy of this Privacy Policy for my personal use.

GENERAL ACKNOWLEDGEMENT

I acknowledge that I have read, understand, and agree to the contents of this document.
I understand and agree to the policies, procedures and fees related to the services that I have requested.

Signature of Person Receiving Services or Legal Representative

Date

Relationship to Person Receiving Services

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Date: _____

Dear Consumer,

Because we are a nonprofit that accepts government funding and foundation grants for some of our services, we are asked to keep certain demographic statistics about the clients we serve.

Your answers to the question below are totally voluntary and confidential. This form will not be a part of, nor ever identified with, the consumer's file.

Thank you for your assistance.

Consumer Ethnic Background:

Native American: _____

Black/African American: _____

Asian: _____

Hispanic/Latino: _____

White: _____

Other Ethnicity: _____

Pacific Islander: _____

Two or more races: _____

Reviewed/Revised: 11/14

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A Non-Profit Organization Serving Individuals With Special Needs Since 1950

The Outcomes Service • The Family Hearing Center • The Katherine Thomas School
The Outpatient Services • The Testing and Tutoring Service • TLC's Summer Programs

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Patient's Name: _____

Dear Doctor:

One of your patients has been referred to TLC —The Treatment and Learning Centers for Testing or Counseling Services. We would appreciate any information you could provide about this patient so that we may have an accurate medical history to consider in our evaluation.

Thank you for your time.

Sincerely,
The Clinical Team at TLC

Return to:

The Treatment and Learning Centers
2092 Gaither Road, Suite 100
Rockville, MD 20850
Attn: Testing & Tutoring Services

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- Adult - Forms\4 - Physician Referral letter and Form - if needed.doc

A Non-Profit Organization Serving Individuals With Special Needs Since 1950

The Outcomes Service • The Family Hearing Center • The Katherine Thomas School
The Outpatient Services • The Testing and Tutoring Service • TLC's Summer Programs



**TESTING DIAGNOSTIC AND SUPPORT SERVICES
PHYSICIAN'S REFERRAL FORM**

Client Name _____ Client Birthdate _____

Client Address _____

Phone (H) _____ (W) _____

Reason for Referral:

Pertinent Medical History:

Current Health Status (please include medication dosage and frequency):

Previous Testing:

Date of Recommended Return Visit:

Additional Comments:

Signature _____ Date _____

Physician's Name (please print) _____

Address _____

Telephone _____

10/09

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