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: SPEECH-LANGUAGE SERVICES

Client Information

Name			
Date of Birth		Sex ☐ M ☐ F	
Home Address	Street _____ Apartment _____ City State Zip Code		
Phone Number	Home	Work	Cell
Emergency Contact	Name	Phone	
Email			

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

Speech and Language History

Chief communication complaint

Date of onset

Cause of problem

Verbal Communication is ❑ Normal ❑ Understandable ❑ Difficult to understand ❑ Absent

❑ Uses an augmentative communication device Device type: _____

Previous Speech Therapy (please include dates and locations)

Describe the type of work you are / were doing in your current or most recent occupation.

Previous Evaluations	**YES**	**NO**	**Date**	**Agency/Person**
Educational / Psychological Testing				
Speech Language Evaluation				
Physical Therapy Evaluation				
Occupational Therapy Evaluation				
Vocational Evaluation				
Previous Therapy	**YES**	**NO**	**Date**	**Agency/Person**
Speech Language Therapy				
Physical Therapy				
Occupational Therapy				
Counseling				

Other Information related to Communication History

Other information you would like us to know about client's communication history:

Circle all areas of concern related to speech, language, or swallowing …		
Receptive	**Expressive**	**Fluency**
Difficulty following directions	Limited vocabulary	Repeats sounds
Difficulty understanding questions	Not using sentences	Repeats words
Difficulty understanding comments of others	Not talking	Repeats phrases
	Difficulty answering questions	Can't get words started
Articulation	Difficulty expressing thoughts	
Unclear speech	Cannot participate in conversation	**Voice and Resonance**
Changes order of sounds in words	Responds with sounds, but not words	Harsh
	Responds by pointing	Hoarse
Thinking Skills/Cognition		Strained / Strangled
Memory ❑ Short-term ❑ Long-term	**Eating and Swallowing**	Too Nasal
Difficulty with focus and attention	Difficulty chewing	
Difficulty with awareness of time, place, location	Choking	
	Coughing during meals	
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	❑ Speak _____ ❑ Understand _____ ❑ Write _____ ❑ Speak _____ ❑ Understand _____ ❑ Write _____

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)?

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		
Blackout		
Cancer		
Diabetes		
Dizziness or vertigo		
Facial numbness		
Head injury		
Heart disease		
High blood pressure		
High fever [greater than 104^0]		
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**

Other Information related to Medical History
Other information you would like us to know about patient's medical history:

Educational History

Circle Highest Grade Completed	1 2 3 4 5 6 7 8 9 10 11 12
Post- High School Education	❑ Some College ❑ College Graduate ❑ Technical School ❑ Advanced Degree: ❑ Other:

Additional information

Other information you would like us to know about the client:		
Primary Care Physician		
Name	Address	Phone

Person Completing this Form	
Relationship to the Client	

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)

- ☐ Audiology
- ☐ Medical
- ☐ Psychological
- ☐ Occupational/Physical Therapy
- ☐ Tutoring/Coaching
- ☐ Other: (describe) _____
- ☐ Speech-Language Therapy
- ☐ 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):

☐ Written	☐ Verbal Exchange	☐ Video / Audio Records	☐ Text Message	☐ Other:
☐ Fax		☐ Voice Mail	Email Yes ☐ No ☐ (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 [*you must be listed if you want a copy of reports*]*:*	
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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SPEECH-LANGUAGE and HEARING DEPARTMENT PHYSICIAN'S REFERRAL FORM

I. Patient Name: _____

Patient Birthdate: _____

Patient Address: _____

_____

Patient Phone: (H) _____ (W) _____

II. Reason for Referral: _____

_____

III. Pertinent Medical History: _____

_____

Medications: _____
(dosage & frequency)

_____

Previous Testing: _____

Contraindications/Precautions: _____

_____

Date of Last Examination: _____

Date of Return Visit: _____

IV. Services Desired: Speech-Language: _____ Audiology: _____

Evaluation Only: _____ Evaluation & Appropriate Intervention: _____

Suggested Treatment Goals: _____

_____

_____

Are there any medical contraindications for the use of amplification or therapeutic Intervention, if recommended? Yes: _____ No: _____

V. Physician Authorization:

Signature: _____ M.D.

Print Name: _____

Telephone: _____ Date: _____