# Robyn Merkel-Walsh MA, CCC-SLP

## Case History Information

Date:_____

Name: _____ DOB: _____

Address: _____ Age: _____

_____ Daytime Phone:_____

_____ Other Phone: _____

Referral Source: _____

What is/are your concern(s)?

Physicians' name and Address:

## I. PERSONAL HISTORY

Occupation _____ Place of Birth_____

1. Who lives in the home?

| Name | Age | Relationship |
|---|---|---|

2. What languages are spoken at home?

3. Is there any history of speech or language problems in the family? If yes, please describe.

4. Is there any history of hearing problems in the family? If yes, please describe.

5. Describe any significant family medical, learning or emotional history.

6. Have you seen any additional specialists?

II. MEDICAL HISTORY

1. Have you been hospitalized? If so, include age, reason and length of stay.

2. History of illness, including age.

3. History of accidents, including age.

4. How would you describe your general health?

5. Do you have allergies or frequent colds? If so, describe.

6. Are you taking any medication? If so, what kind and why?

7. Have you had your hearing tested? If so, when and what are the results?

8. As a child how was your health?

III FUNCTIONAL INFORMATION:

1. Do you have any feeding difficulties or history of feeding issues as a child? (e.g., drooling, swallowing).

2. Do you avoid any foods?

3. Do you have any oral habits such as nail biting?

4. Did you or do you currently use a pacifier or suck your thumb?

5. Do you grind your teeth?

6. Do you breathe through your nose?

7. When you sleep do you snore? Drool? Wake up with head or jaw pain?

8. Do you grind your teeth?

9. Have you had orthodontia or dental problems?

10. Do you have any sensory issues, such as sensitivity to smell, light, and touch?

11. Do you have any balance or coordination difficulties? If so, please describe.

12. How are your sleeping patterns?

13. How clear do you feel your speech is?

III. SOCIAL HISTORY

1. How would you describe your personality?

2. Do you smoke or drink?

3. Do you have any embarrassment or anxiety about your current condition?

VII. Is there any other information about you that may be helpful in this evaluation? (Explain on back please.)

| | |
|---|---|
| NAME OF CLIENT | |
| ADDRESS | |
| PHONE #S | |
| SCHOOL | |
| PEDIATRICIAN | |
| INSURANCE | |

I _____ parent of _____ give Robyn Merkel, Speech Pathologist, permission to discuss my child's case with the following individuals via in person , email, or phone:

| **NAME** | **PHONE # / EMAIL** |
|---|---|
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Signed:

_____

I give Robyn Merkel permission to mail copies of my child's reports the school district, pediatrician and/or other specialist on the occasions which I have listed below:

| Date | Report sent to……. | initials |
|---|---|---|
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# Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE DISCLOSED AND HOW YOU MAY HAVE ACCESS TO YOUR "PROTECTED HEALTH INFORMATION" (PHI). PLEASE REVIEW THIS INFORMATION CAREFULLY, AND SIGN THIS FORM BELOW AFTER READING IT.**

We care about our patients' rights 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.

## 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 this 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 uses or disclosures. Not every possible use or disclosure in a category is listed.

## For Treatment

We may use medical information about you to provide you with medical treatment or services. Example: In treating for specific motor-speech, or language impairment, we may need medical diagnoses from neurologists or other physicians. This office may use your PHI in providing health care to you. We may use your PHI during office visits or when providing health care in a hospital setting. Under federal law, we may disclose your PHI to you or when we forward your medical information to that physician. We can also disclose your PHI for payment purposes (such as your insurance provider, employer, Medicare or other parties responsible for providing you with health insurance coverage) so that you may be reimbursed for your services. We may also use your PHI for health care operations (quality assurance and medical chart reviews). We may disclose your PHI when required by the secretary of the US Department of Health and Human Services.

## 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 or school district for payment. Diagnostic and Procedure Codes are required for payment from insurance companies.

## For Health Care Operations

We may use and disclose medical information about you to health care operations (including employees of Good Talking People LLC, speech pathologists, and medical professionals) 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
- In response to a legal proceeding
- 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

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## Patient Acknowledgement of Notice of Privacy Practices (as previously stated)

**Patient Name:** _____

**Date of Birth:** ____/____/____

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice will provide me a revised Notice of Privacy Practices upon request.

_____ (Signature)

_____ (Relationship to patient)

_____/_____/_____
(Today's Date)