Community Speech Services INC

Welcome to Community Speech Services, Inc.!

Community Speech Services, Inc. is a private practice whose services are focused on increasing or improving their clients' communication skills.

Communication difficulties affect millions of children and adults. (Communication disorders constitute the nation's number one handicapping disability). The degree of how each individual is affected is dependent on communication used in their daily activities. For instance, a child with only a slight lisp may be reluctant to read aloud in class. Or an adult with an articulation disorder may be misunderstood at work. Many clients who are diagnosed "non-verbal" have limited education/vocational opportunities. A child with autism may need practice with social skills. Thus, Community Speech Services, Inc. thoroughly evaluates each individual and works with them and/or their family to establish appropriate goals.

We are conveniently located off I-77 on Massillon Road (Route 241). GPS address to our office is 4700 Massillon Rd, N. Canton, OH 44720. Our office is wheelchair accessible. Please contact us if you have any additional questions at (330)896-9119.

Evaluation	$250.00
Therapy	$50.00

We accept Medicaid, BCMH and most commercial insurance plans.

PLEASE BRING THE FOLLOWING TO YOUR FIRST APPOINTMENT:

* NEW PATIENT PAPERWORK COMPLETED
* INSURANCE CARDS
* COPY OF EVALUATION & ANY OTHER DOCUMENTATION YOU MAY FIND BENEFICIAL TO THERAPIST FOR UPCOMING APPOINTMENT
*PRIMARY CARE REFERRAL/ORDER

AT THIS TIME DUE TO COVID 19 RULES & REGULATIONS WE ARE ASKING THAT FAMILIES REMAIN IN THEIR CAR UPON ARRIVAL. WHEN YOU ARRIVE TO THE OFFICE FOR YOUR SCHEDULED SPEECH APPOINTMENT PLEASE CALL INTO THE OFFICE 330-896-9119 & LET US KNOW AND YOUR CHILDS THERAPIST WILL COME OUT TO GET YOU

4700 Massillon Road
P.O. Box 667
Green, OH 44232
Akron 330.896.9119
Fax 330.896.1185

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Green, OH 44232

Evaluation date/1st session date/time:
Therapist:
DX Code:

I. IDENTIFICATION

Name:	Age:	Birthdate:
Address:	City:	Zip:
Home Phone:	School Name:	Grade:
Referred By:		

Names of physicians who are currently treating your child (if applicable):

Pediatrician:		Phone:	
ENT:		Phone:	
Other:		Phone:	

II. FAMILY HISTORY

Father:	Cell:	Work:	E-mail:
Place of Employment:		Education:	

Marital Status:

Single		Married		Divorced		Separated		Widowed	

Mother:	Cell:	Work:	E-mail:
Place of Employment:		Education:	

Marital Status:

Single		Married		Divorced		Separated		Widowed	

List full names and ages of brothers, sisters and family pets (this will help us individualize therapy sessions):

NAME	AGE	RELATION

Contact Email Address: _____

III. PREVIOUS EVALUATIONS AND THERAPY

Has your child ever been evaluated for the following?:

	Y/N	When	Where	Results
Speech and Language				
Hearing				
Phsychological/Neurological				
Physical Therapy/Occupational Therapy				

IV. SPEECH/LANGUAGE/SWALLOWING DIFFICULTIES

What are your greatest concerns about your child's communication or feeding skills?

_____
_____
_____

V. MEDICAL HISTORY

Child's present health _____
Vision _____ Hearing _____ Attention _____
Have you noted any chewing/feeding/swallowing difficulties? _____
If so, please describe _____
Known allergies (food and drug) _____
Circle types of medical treatment:
Seizures High Fevers Ear Infections Asthma ADD/ADHD Other_____
List any serious injuries/operations: _____
Does child have tubes in ear(s) at this time or in the past? If so, when placed? _____
Has child had tonsils and/or adenoids removed? _____
Has child had his/her "tongue clipped"? _____
Current medications (why being taken and dosage) _____

VI. DEVELOPMENTAL MILESTONES

At what approximate age did child: sit_____ Crawl_____ walk_____ feed self_____ dress self_____
Overall coordination of child: average_____ fair _____ poor_____
Explain_____

VII. SPEECH LANGUAGE AND HEARING HISTORY

Was rate of language development: average_____ fair _____ poor_____
Is a second language spoken in the home? _____
Does child use gestures to communicate instead of words? _____
Does child avoid speaking? _____Recognize own difficulty? _____
Does child use pacifier? _____ Suck thumb, fingers, toys? _____
Does child drool? _____
Is child's speech understood by: parents____ peers____ relatives____ neighbors ____ teachers ____ strangers ____
When was difficulty first noticed? _____ By whom? _____
Give examples of child's present speech: _____
_____
_____
Have you ever questioned child's hearing ability? _____

VIII. SOCIAL HISTORY

(Responses to these questions will help us individualize the evaluation/therapy session)
Describe child's behavior and personality_____
_____
_____
How does he/she play with others (peers , family etc…)?_____
_____
Favorite activites
Favorite toys_____

Are there themes not permitted in your home? (Ex: superheroes, Barbie, guns, Christmas, Halloween, ninja turtles, rugrats, etc…) Please specify what, if anything you do not want mentioned in therapy:_____
_____

IX. ADDITIONAL INFORMATION

Please provide any additional information about the child that may be helpful for this facility to be aware of to best serve the child:_____
_____
_____

FORM COMPLETED BY:_____
RELATIONSHIP TO CHILD:_____
DATE FORM COMPLETED:_____
DATE SCHEDULED AT THIS FACILITY:_____

Please attach copies of the following documents: (if applicable)
Physicians order for evaluation and treatment (if available)
Previous speech and language evaluations
Previous hearing evaluations
School IEP

_____

PRIVACY PRACTICES/ CONSENT TO TREAT/ PAYMENT

I have received a copy of Community Speech Services NOTICE OF PRIVACY PRACTICES, effective January 2018.

I also give consent for Community Speech Services to treat my child based on the plan of treatment disclosed to me at the time of the evaluation or first treatment.

I agree to pay Community Speech Services, Inc. any amount which has not been paid to community speech Services, Inc. by any third party insurer.

_____ _____
Parent Signature Date

I give permission for my child to be photographed/videoed for our website or learning purposes:
Yes No (circle one) Signature: _____ Date: _____

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EMERGENCY CONTACT
(UPDATE 2020)

Client Name: _____

Contact Name: _____ Phone: _____
Contact Name: _____ Phone: _____

Community Speech Services INC

INSURANCE INFORMATION

(Please Print)

Patient: _____ D.O.B.:_____ ***IF PRIVATE PAY OR HAVE CHOSEN NOT TO BILL INSURANCE PLEASE FILL OUT RESPONSIBLE PARENT, D.O.B. & SOCIAL SECURITY NUMBER, THEN SKIP MIDDLE INSURANCE PORTION SIGN & DATE BOTTOM OF FORM***

Insured/Responsible Parent: _____ D.O.B.:_____
Social Security #: _____

Verification of your insurance coverage does not guarantee benefits or payment. All claims are subject to your plan(s) limitations and exclusions. Please refer to your insurance policy or contact your insurance company regarding specific coverage issues.

	Primary Insurance	Secondary Insurance
Name of Company		
Insurance Company Address		
Group/Policy #		
Insured's Identification #		
Verified By CSS (Date)		
Pre-certification needed?		
Co-pay Amount		
Annual Deductible		
Amount of Deductible Met		
Coinsurance %/Patient's %		

Coverage limitations:
_____

The self-pay portion of the account balance may be paid by check, cash or credit card. ***Co-pays are due at the time of service*** but can be paid in advance for your convenience.

PATIENT ACKNOWLEDGEMENT:
I hereby agree to make payment in full if the insurance company denies the claims.

_____
Signature

4700 Massillon Road
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Akron 330.896.9119

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Community Speech Services INC

PERMISSION TO OBTAIN INFORMATION

I hereby give permission to Community Speech Services to obtain diagnostic and/or therapeutic information concerning:

_____
Name of Client

_____
Street

_____
City State Zip

FROM:

1.Physician(s)_____ _____
_____ **Date**
_____

2.School_____ _____
Phone #_____ **Fax #** _____ **Date**
Permission to obtain IEP/ETR from school: YES or NO

3.Other_____ _____
_____ **Date**
_____

Information Requested

_____

_____

_____

_____ _____
Signature and Relationship to Client **Date**

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Community Speech Services INC

PERMISSION TO RELEASE INFORMATION

I hereby give permission to Community Speech Services to release diagnostic and/or therapeutic information concerning:

_____
Name of Client

_____
Street

_____
City State Zip

to:

1.Physician(s)_____ _____
_____ **Date**
_____
_____

2.Insurance_____ _____
_____ **Date**
_____
Permission to release IEP/ETR to insurance company if requested? YES or NO

3.School/Employer_____ _____
_____ **Date**
_____
_____

I UNDERSTAND THAT NO VERBAL OR WRITTEN INFORMATION WILL BE RELEASED WITHOUT WRITTEN PERMISSION.

_____ _____
SIGNATURE AND RELATIONSHIP **Date**

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CSS Speech Therapy Attendance Policy

- **A 24 hour cancellation notice is required, or a $25.00 fee will be charged.** We understand emergencies and sickness arise, and we will attempt to re-schedule your appointment so you/your child will not miss therapy, and the fee will be waived.

- A client who fails to attend 3 appointments within a 90 day period without a phone call or notification **may be discharged** from therapy. The client will be notified after each "no show".

- An attendance rate of 70% or below may result in dismissal from therapy. It should be noted that every attempt will be made to accommodate the client's schedule to ensure continuation of services.

- If a client is unable to attend therapy for a period of 30 to 60 days they may request a temporary dismissal from therapy. Once able to attend regularly, they can call and schedule therapy again.

_____ _____

Client or Parent's Signature Date

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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 READ CAREFULLY.

We are required by law to maintain the privacy of protected health information (PHI) and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. We are required to follow the practices described in this Notice. We reserve the right to change our privacy practices and the terms of this Notice at any time. If we change our notice, we will post the revised notice in the facility and will have them available upon request. You can receive a copy of the current notice at any time. This Notice describes how we have extended certain protections to your PHI and how, when, and why we may use and disclosure your PHI. With certain exceptions, we will use or disclose your PHI in the minimum necessary manner to accomplish the intended purpose of the use or disclosure. We will share PHI as is necessary to provide quality health care and receive reimbursement for those services as permitted by law. To the extent there is stricter Ohio or federal law regulating the privacy of your PHI, we will comply with the stricter provisions of law.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

We are committed to maintaining the confidentiality of your health information. Your health information may be used and disclosed for purposes of treatment, payment, and health care operations. Outside of these permitted uses, we must have your written and signed authorization unless the law permits or requires the use or disclosure without your authorization. You have the right to revoke that authorization in writing except to the extent any action has been taken in reliance on the authorization.

Treatment, Payment, and Health Care Operations. With your consent and authorization, we may use and disclose your health information for purposes of treatment, payment, and as otherwise necessary and permitted by law, for our health care operations. This may include disclosure to another health care provider who, at the request of your physician, becomes involved in your treatment, for purposes of approval of reimbursement from your health plan, or for audit purposes, we may disclose to our accountant or attorney.

Business Associates. It may be necessary for us to provide your health information to certain outside persons or entities that assist us with our health care operations, such as auditing, accreditation, legal services, etc. These business associates are required to properly safeguard the privacy of your health information.

Appointments and Services. We may contact you to provide appointment reminder, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

USE AND DISCLOSURES REQUIRING YOU TO HAVE AN OPPORTUNITY TO OBJECT.

Family and Friends. We may use our professional judgment when disclosing your health information to designated family, friends, and others who are directly involved in your care or in the payment for your care, unless you object. If you are unavailable, incapacitated, or in an emergency medical situation, and we determine that a limited disclosure may be in your best interest, we may share limited health information with such individuals without your approval.

USES AND DISCLOSURES OF PHI.

We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give out medical information about you without prior authorization for public health purposes, accrediting organizations such as JCAHO, required abuse or neglect reporting, health oversight audits or inspections, research studies, funeral arrangements and organ donations, worker's compensation purposes, and emergencies. We also disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances or in response to valid judicial or administrative orders. We may use or disclose your medical information. We may use or disclose your medical information for research purposes but only with your prior authorization or a proper waiver of authorization form the IRB or Privacy Board.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Restrictions on Use and Disclosure of Individual Health Information. You have the right to request that we restrict how we use and disclosure your health information. These restrictions must be made in writing and signed by you or your representative. We are not required to agree to your restrictions. We cannot agree to limit uses/disclosures that are

required by law. In the event of a termination of an agreed-to restriction by us, we will notify you of such termination. You may terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the Privacy Official.

Access to Individual Health Information. You have the right to inspect and copy your health information. All such requests must be made in writing and signed by you or your representative. A reasonable per page fee will be assessed if you request a copy of the information. There will also be a charge for postage if you request a mailed copy and, if requested, for preparation of a summary of the requested information. You may obtain a Request for Access form from the Privacy Official. We will respond within 30 days unless an extension is taken. In certain circumstances, you may not be permitted access. Depending on the circumstances, you may request a review of the decision to deny access. If we deny your request, you will be given written notice that will explain the basis and your right to appeal.

Amendments to Individual Health Information. You have the right to request that your health information be amended or corrected. We will respond within 60 days unless an extension is taken. In certain cases, we may deny your request for amendment and you will be given written notice that will explain the basis and your right to appeal, which will be appended to your health information. You may also submit a statement of disagreement and we may prepare a rebuttal that will be provided to you. All amendment requests must be in writing, signed by you or your representative, and must state the reasons for the amendment. If we make an amendment, we may notify others who work with us and have copies of the un-amended record if we believe that such notification is necessary. You may obtain a Request for Amendment form from the Privacy Official.

Accounting for Disclosures of Individual Health Information. You have the right to receive an accounting of certain disclosures of your health information made by us after April 14, 2003. Requests must be made in writing and signed by you or your representative. Request for Accounting forms are available from the Privacy Official. The first accounting in any 12 month period is free; you will be charged a reasonable fee for each subsequent accounting within the same twelve month period. The right to receive this information is subject to certain exceptions, restrictions, and limitations.

Confidential Communications. You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of a specific way or location for us to use to communicate with you.

Right to a Paper Copy. You have the right to receive an additional paper copy of this or any revised Notice and/or an electronic copy by email upon request to the Privacy Official.

How to Complain About Our Privacy Practices.
If you believe that we may have violated your privacy rights, or you disagree with a decision about your PHI, you may file a complaint with the Privacy Official listed below. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, SW, Washington D.C. 20201 or call 1-877-696-6775. There will be no retaliation for filing a complaint.

If you have questions about this Notice or any complaints about our privacy practices, please contact:
Sara E. Wolosiansky, Director
Community Speech Services
4700 Massillon Road, P.O. Box 667
Green, OH 44232
(330) 896-9119
This notice is effective April 14, 2003.