PATIENT INFORMATION & DEVELOPMENTAL HISTORY

PLEASE COMPLETE ALL LINES ON THIS FORM.

WE ALSO NEED THE FOLLOWING:

COPY OF PRIMARY CARE INSURANCE CARD

COPY OF SECONDARY CARE INSURANCE CARD

THANK YOU FOR CHOOSING US AS YOUR HEALTHCARE PROVIDER

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION TO PROCESS CLAIMS, AND AUTHORIZE AND ASSIGN PAYMENT OF MEDICAL BENEFITS DIRECTLY TO SPEECH PATHOLOGY SERVICES OF EAST TENNESSEE DBA RADIANT COMPREHENSIVE THERAPY SERVICES FOR SERVICES RENDERED. I UNDERSTAND THAT I WILL NOT BE CHARGED FOR ANY SERVICES RECEIVED IN ACCORDANCE WITH THE IEP. I ACKNOWLEDGE RECEIPT OF RADIANT COMPREHENSIVE THERAPY SERVICES “INSURANCE AND FINANCIAL POLICY”. I ACKNOWLEDGE RECEIPT OF THE PATIENT CARE POLICY AND UNDERSTAND MY RIGHTS AND RESPONSIBILITIES ACCORDING TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT.

☐ Speech-Language Therapy
☐ Physical Therapy
☐ Occupational Therapy

PARENT OR LEGAL GUARDIAN SIGNATURE OF MINOR PATIENT

DATE ______________________
NAME OF PERSON COMPLETING THIS FORM____________________________________ RELATIONSHIP TO PATIENT________________________

PATIENT’S NAME ____________________________________________________________
(CHILD’S) LAST NAME FIRST NAME MIDDLE NAME OR INITIAL

STREET ADDRESS________________________________________________________________________

CITY, STATE, ZIP _______________________________________________________________________

HOME PHONE NUMBER____________________________ COUNTY _____________________________

SOCIAL SECURITY NUMBER____________________________ DATE OF BIRTH________________________ AGE ______________

SEX:  M  F  COPY OF INSURANCE CARD ATTACHED:  Y        N

SCHOOL PATIENT ATTENDS ______________________________ TEACHER___________________________ GRADE LEVEL ____________

THIS CHILD LIVES WITH  (CIRCLE ONE)  BOTH PARENTS  MOTHER  FATHER  OTHER (PLEASE EXPLAIN): _________________________________

PARENT/LEGAL GUARDIAN INFORMATION

NAME ______________________________________________________ NAME ______________________________________________________

ADDRESS ____________________________________________________ ADDRESS __________________________________________________

____________________________________________________                     _________________________________________________

HOME PHONE ________________________________________________ HOME PHONE _____________________________________________

CELL PHONE _________________________________________________ CELL PHONE _______________________________________________

OKAY TO TEXT?      YES      NO                                                                                OKAY TO TEXT?      YES      NO

EMAIL _______________________________________________________ EMAIL ____________________________________________________

OKAY TO EMAIL?      YES      NO                                                                              OKAY TO EMAIL?      YES      NO

Text and email messages may contain protected health information

PLEASE LIST THE NAMES AND AGES OF ALL OTHER INDIVIDUAL’S LIVING IN THE CHILD’S HOME:

_______________________________________________________________________________

_______________________________________________________________________________

EMERGENCY CONTACT (Name of relative or friend not living with you):

NAME_________________________________________________________ RELATIONSHIP____________________________________

HOME PHONE_________________________________________________ CELL PHONE_________________________________________

NAME __________________________________________________________________RELATIONSHIP __________________________________
**MEDICAL INFORMATION**

**First Name**  
**Last Name**  

**WE WILL BE CONTACTING THE DOCTOR TO REQUEST A PRESCRIPTION FOR SERVICES. DOCTOR’S REQUIRE THAT YEARLY EXAMS BE UP TO DATE TO PROVIDE THIS PRESCRIPTION**

LIST ANY DIFFICULTIES DURING PREGNANCY (Health, Illness, Injuries, Medication) ________________________________________________________________

**WAS THE PREGNANCY FULL TERM? YES NO**  
LIST ANY PROBLEMS DURING LABOR & DELIVERY ________________________________________________________________

**WAS THE CHILD MEDICALLY HEALTHY AT BIRTH?** ________________________________________________________________

LIST ANY FEEDING DIFFICULTIES THIS CHILD HAD ________________________________________________________________

OR IS STILL EXPERIENCING ________________________________________________________________

LIST ANY SPEECH/PHYSICAL/OCcupational therapy THIS CHILD HAD ________________________________________________________________

OR IS STILL RECEIVING ________________________________________________________________

GENERAL HEALTH OF THIS CHILD IS (CIRCLE ONE) **EXCELLENT GOOD POOR**  
**DOES S/HE HAVE “PE” TUBES? YES NO**

HAS THIS CHILD HAD FREQUENT EAR INFECTIONS? **YES NO**

HAS THE CHILD’S HEARING BEEN TESTED? **YES NO**  
**IF YES, WHEN AND WHAT WERE THE RESULTS:** ________________________________________________________________

HAS THIS CHILD BEEN HOSPITALIZED? **YES NO**  
**IF SO, PLEASE DESCRIBE** ________________________________________________________________

PLACE A CHECK MARK BESIDE ANY OF THE FOLLOWING THIS CHILD HAS/HAD:

- Arthritis  _____  - EPILEPSY  _____  - Heart Trouble  _____  - Nervous Condition  _____
- Dentures  _____  - Implants  _____  - Headaches  _____  - High Blood Pressure  _____
- High Fever  _____  - clumsiness  _____  - Frequent Colds  _____  - Vision Difficulties  _____
- Seizures  _____  - Weakness  _____  - Kidney Disease  _____  - Attention Problems  _____
- Diabetes  _____  - Fractures  _____  - Hyperactivity  _____  - Shortness of Breath  _____
- Cancer  _____  - Asthma  _____  - Sinus Infections  _____  - Behavior Problems  _____
- Allergies  _____  - Strep Infections  _____  - Sensory Issues  _____

LIST ALLERGIES TO MEDICATIONS & FOODS  

LIST ALL MEDICATIONS THIS CHILD IS CURRENTLY TAKING  

**WAS THIS CHILD DIFFERENT IN ANY WAY FROM SIBLINGS OR OTHER CHILDREN? EXPLAIN.** ________________________________________________________________
APPROXIMATELY AT WHAT AGE DID THE FOLLOWING TAKE PLACE:

FIRST WORDS ___________  PUT 2 WORDS TOGETHER ___________  SITTING UP ___________
ROLLING OVER ___________  CRAWLING ___________  FIRST STEPS ___________

HAS THIS CHILD HAD ANY PRE-SCHOOL, SCHOOL OR DAYCARE EXPERIENCE?  YES  NO

IN GENERAL, THIS CHILD’S DEVELOPMENT HAS BEEN: (Please Circle)  SLOW  NORMAL  ADVANCED

IS THERE ANY OTHER INFORMATION ABOUT THIS CHILD YOU THINK WILL BE HELPFUL TO US IN PROVIDING CARE FOR HIM/HER?

_________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________

HEALTH INSURANCE

Please list all insurance policies (Private and TennCare). We cannot collect payment without this information. If the information listed below changes, contact Radiant Comprehensive Therapy Services ASAP (865-982-3400). Please keep a copy of this information as a reminder to contact us if it changes.

**PRIMARY INSURANCE**: ____________________________ Insurance Company’s Phone #: ____________________________

Cardholder’s Name:____________________________________________________________________________________

Cardholder’s Date of Birth:______/______/______  Social Security #:_______-_______-_______

Relationship to patient: _______________________________________________________________________________

Policy / ID #:_________________________________________  Group #:_________________________________________

**SECONDARY INSURANCE**: ____________________________ Insurance Company’s Phone #: ____________________________

Cardholder’s Name:____________________________________________________________________________________

Cardholder’s Date of Birth:______/______/______  Social Security #:_______-_______-_______

Relationship to patient: _______________________________________________________________________________

Policy / ID #:_________________________________________  Group #:_________________________________________

Attach a copy of all insurance cards so that we may obtain authorization for services and verify eligibility and benefits. If there are more than two insurance policies, please list additional information on the back of this page.

Thank you,
Radiant Comprehensive Therapy Services
Consent to Access to Information

Student Name: ___________________________ Birth Date: ________________

School District: ________________________________

By signing this Release form, you allow your child's school, along with the Bureau of TennCare, your child's health care providers and your child's TennCare managed care organization to release documents to each other containing educational records about your child. The following records may be disclosed:

1. Your child's Individual Educational Plan (IEP);
2. Medical and psychology records, including this type of information that is contained in your child's educational records; and
3. Educations reports, records or relevant test results contained in your child's educational records

The purpose for allowing these records to be shared is so that the people providing health care related services can talk with your child's school about your child and those services. In addition, allowing these records to be shared also makes it so that your child's school can verify whether your child is on TennCare so that the school can ask TennCare to pay for eligible school-based health services under the Individuals with Disabilities Education Act. If you sign this release form, you will be giving consent for the records listed above to be released to the Department of Education school district, their billing agent(s), the insured's physician(s), and TennCare representatives as needed.

Note: You are not required to sign this Release form in order for your child to receive services in their IEP. Those services will still be provided to your child at no cost to you. If you do sign the Release form, you have the right to later withdraw or revoke your consent at any time by sending a letter to the Director of Special Education.

By signing this form, I am saying that:

✓ I have received a copy of the Notice of Access to Information.
✓ I understand and agree that __________________________ (name of school district) may access my child's public benefits or insurance information in order to seek reimbursement for services rendered as listed on the Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP).
✓ I understand and agree that the records and information listed above may be released for the purposes described in this release to the people or organizations identified above.

DATE: __________________________

Signature of Parent/Guardian: ______________________________
Notice of Access to Information

This Notice is to inform parents that the following information may be accessed in order for their child's school to provide special education or related services:

- Insurance or public benefits information of the parents, legal guardians and children, and
- The child's educational records, including their Individualized Education Plan (IEP) and any personally identifiable or medical information contained in the child's educational records

Along with this Notice, you will receive a Release form. The Release form allows your child's school, TennCare, your child's health care providers and your child's TennCare managed care organization to release documents to each other containing educational records about your child. The following records may be disclosed:

1. Your child's Individual Educational Plan (IEP);
2. Medical and psychology records, including this type of information that is contained in your child's educational records; and
3. Education reports, records or relevant test results contained in your child's educational records

Allowing these records to be shared like this will make it so that the people providing health care related services can talk with your child's school about your child and those services. In addition, allowing these records to be shared also makes it so that your child's school can verify whether your child is on TennCare so that the school can ask TennCare to pay for eligible school-based health services under the Individuals with Disabilities Education Act. If you sign the release form, you will be giving consent for the records listed above to be released to the Department of Education school district, their billing agent(s), the insured's physician(s), and TennCare representatives as needed.

Note: You are not required to sign the Release form in order for your child to receive services in their IEP. Those services will still be provided to your child at no cost to you. If you do sign the Release form, you have the right to later withdraw or revoke your consent at any time by sending a letter to the Director of Special Education.

Neither TennCare nor the school:

- May require you to sign up or enroll your child in TennCare or any public benefits or insurance program so that your child can get a free appropriate public education;
- May require you to make an out-of-pocket payment of a deductible or a co-pay amount to file a claim for services
- May use your child's TennCare benefits if by doing so it would:
  - decrease your child's available lifetime coverage or other insured benefit, OR
  - make You pay for services that would otherwise be covered by TennCare or another program while your child is in school, OR
  - cost more or discontinue coverage for the program, OR
  - make your child miss out on home and community-based services because of the State's overall costs.

...
PATIENTS’ RIGHTS AND RESPONSIBILITIES

- Every patient has the right to reasonable access to care, delivered with consideration and respect.
- Every patient has the right to request and receive information regarding the identity and professional status of any staff member providing care to him or her.
- Every patient has the right to be free from the use of seclusion or restraint, in any form, as a means of coercion, discipline, convenience or retaliation by staff.
- Every patient has the right to receive care in a setting free from verbal or physical abuse or harassment, and the right to protection by other staff members in the event that a staff member or member of the public violates those rights.
- Every patient has the right to the zealous protection of privacy and confidentiality, including medical records.
- Every patient has the right to register a complaint with Radiant without jeopardizing future care. Complaints should be addressed to the Chief Manager in the event that a successful resolution with the staff member directly involved is not possible. Complaints do not have to be placed in writing, and it shall be the duty of each employee to assure that all oral complaints are properly communicated to Radiant.
- Every patient has the right to express his or her individual religious beliefs or cultural practices as long as they do not interfere with effective diagnostic procedures or treatment.
- Every patient has the right to be informed about his or her diagnosis, treatment plan, and prognosis; the risks, benefits and alternatives of any treatments or procedures; and instructions for follow-up care. Each patient has the right to make decisions about care and to participate in developing and implementing a treatment plan.
- Every patient has the right to refuse treatment and be informed of the consequences of this action. Likewise, every patient has the right to change his or her mind about any treatment for which consent has already been given.
- Every patient has the right to examine his or her medical bill and medical record and to receive an explanation of charges or care, unless restricted by law.
- Every patient has the right to have his or her duly authorized representative to exercise these rights (to the extent legally permissible) in the event he or she is unable to do so.
- Every patient has the right to consent to or decline to participate in research affecting his or her care.
- Every patient has the right to consent to or decline to the assignment of students in health professional training to his or her care.

PATIENT CONFIDENTIALITY

- All patients are entitled to the zealous protection of their personal identifiable health information, regardless of whether that information is contained in oral communications, electronic information, or written records in accordance with HIPAA guidelines.
- All questions regarding confidential patient information are to be directed to the Chief Manager, who is designated as the agency’s Privacy Official.
- No patient records or personal health information of a patient are to be released to any third party without the written consent of the patient, parent or guardian, except as required by law or for treatment, payment, or operational purposes.
- All staff is expected to converse with one another (and with patients or treating physician’s offices) in a respectful and an appropriate manner, and to take all reasonable steps to assure the confidentiality of all oral communications.
- As provided elsewhere in these policies, except when in use, patient records are to be stored in locked file cabinets.