WISE
Woolley Institute for Spoken-Language Education

Child's Name: _____ Preferred Name: _____

Date of Birth: _____ Sex: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Address (if different): _____

Mother's Name: _____ Cell #: _____

Work #: _____ Email Address: _____

Employer: _____

Father's Name: _____ Cell #: _____

Work #: _____ Email Address: _____

Employer: _____

Degree of Hearing Loss: _____ Amplification used: _____

Date your child received hearing aids/cochlear implants, if applicable: _____

Current Audiologist: _____

Current Speech-Therapist: _____

Child's current school system: _____

Special Education Coordinator: _____ Phone #: _____

Current Services being received: _____

Please list any previous individual therapy, name of therapy provider and duration of enrollment in therapy:

_____

_____

Developmental

Fill in the approximate age your child began to:

_____ Roll over

_____ Full head control

_____ Sit alone

_____ Crawl

_____ Pull to stand

_____ Walk alone

_____ Potty train

_____ Imitate gestures

_____ Roll a ball and return it in play

_____ Babble

_____ Put two words together

_____ Said first words

_____ Spoke in short sentences

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How does your child communicate? (cries, babbles, gestures, uses words, uses baby signs, exhibits protest behaviors): _____

_____

What daily routines are challenging for your child? (mealtime, sleeping, community outings): _____

_____

What does your child like to do? List toys he/she likes, food he/she likes, anything that makes him/her happy:

_____

_____

Does your child:

- ☐ choke on food or liquids?
- ☐ put toys/objects in his/her mouth?
- ☐ brush his/her teeth and/or allow brushing?

Check all that apply:

- ☐ Child does not respond to people or things around him/her
- ☐ Child shows some awareness of people and objects (smiles/laugh)
- ☐ Child responds to simple games
- ☐ Childs plays by him/herself with simple toys
- ☐ Child uses parallel play
- ☐ Child participates in turn-taking gmaes
- ☐ Child points to a person or thing to gain attention
- ☐ Child enjoys pretend play
- ☐ Child gains an adult's attention to look at something interesting
- ☐ Child does not obey commands
- ☐ Child has frequent tantrums and/or crying
- ☐ Child withdraws
- ☐ Child will frequently hit, kick, bite or spit
- ☐ Child shows self-injurious behavior
- ☐ Child shows self-stimulating behavior

Medical Information

Has your child ever had trouble breathing? If yes, explain: _____

_____

Has your child had a vision exam? ☐ yes ☐ no

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Does your child have vision challenges? ☐ yes ☐ no

If yes, explain: _____

Is your child currently taking medicine? ☐ yes ☐ no

If yes, what type of medication, the amount, and time given: _____

_____

Has your child ever been hospitalized? ☐ yes ☐ no

If yes, please list hospital, date and reason: _____

_____

Has your child ever had any significant injuries? ☐ yes ☐ no

If yes, please describe: _____

_____

Does your child have allergies? ☐ yes ☐ no Is your child allergic to latex? ☐ yes ☐ no

If yes, list allergies and describe reaction: _____

_____

What illnesses has your child had? _____

_____

Please list any medical diagnosis: _____

_____

Has your child had any genetic testing? ☐ yes ☐ no

If yes, explain: _____

_____

Preferred Hospital: _____

Doctor's Name: _____ Doctor's #: _____

Medical Insurance: _____

Policy #: _____

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Emergency Contact #1: _____

Relationship: _____ Phone #: _____

Emergency Contact #2: _____

Relationship: _____ Phone #: _____

The following people have permission to pick up my child (prepared to show ID):

1. 4.

2. 5.

3. 6.

_____ _____

Signature of Parent/Guardian Date

All students accepted for enrollment enter a 20-day trial basis. If at any time during the enrollment period, the teachers and therapists agree that the Woolley Institute for Spoken-Language Education (WISE) does not meet the specific needs of the child, or that the child does not respond to the program, we reserve the right to make recommendations for placement in other programs.

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CONSENT FOR EMERGENCY MEDICAL CARE

I, _____, do hereby authorize the staff of the Woolley Institute for Spoken-Language Education (WISE) to obtain such medical or surgical aids as may be deemed necessary and expedient by a duly-licensed or recognized physician or surgeon in case of an emergency when the parents or guardian cannot be reached.

Child's Name: _____

DOB: _____

Name of Child's Doctor: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Emergency #: _____

It is my understanding that in the event of a medical emergency involving my child, every attempt will be made to reach me or the Emergency Contact Person I have listed above for my child. If the Woolley Institute for Spoken-Language Education (WISE) cannot reach me, then I authorize the school to employ a doctor or other healthcare professional, and I hereby give my permission to provide medical services that are deemed necessary.

_____ _____

Signature of Parent/Guardian Date

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Woolley Institute for Spoken-Language Education

PERMISSIONS

Child's Name: _____ DOB: _____

Please sign beneath all applicable subject matter

1. I give permission for the Woolley Institute for Spoken-Language Education (WISE) to release photographs/videos of my child for publications the administration has approved.

_____ _____
Signature of Parent/Guardian Date

2. I give permission for WISE to videotape my child and to use such videos for professional training and/or as examples of therapy/classroom sessions to be shown to visitors.

_____ _____
Signature of Parent/Guardian Date

3. I give permission for WISE to email/text message me at the previously listed email address/phone number. I understand that communicating information by email/text message has a number of risks. I understand that WISE will limit emails/text messages to contain only non-confidential information. All communication of delicate nature will be conducted via telephone conversations or through parent/teacher meetings.

_____ _____
Signature of Parent/Guardian Date

4. This consent is effective one (1) year from the date signed. I understand that I may revoke this consent in writing at any time.

_____ _____
Signature of Parent/Guardian Date

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PERMISSION FOR THE RELEASE OF INFORMATION RECORDS

Child's Name: _____ DOB: _____

Child's Address: _____

City: _____ State: _____ Zip: _____

Parent/Guardian's Name: _____

I, _____, give my permission for the Woolley Institute for Spoken-Language Education (WISE) to release information on my child. I know my permission is voluntary and at any time can be refused to any individual or agency.

The agency allowed to release information is:

The Woolley Institute for Spoken-Language Education (WISE)

The information should be sent to:

Name: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip: _____

The following written, verbal or audio/video information may be released:

[ ] *Speech/Language Testing/Reports*

[ ] *Staffing Reports, IEPs*

[ ] *Audiologic Reports*

[ ] _____

_____ _____

Signature of Parent/Guardian Date Signed

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SOCIAL MEDIA RELEASE

Child's Name: _____ DOB: _____

I, _____, legal guardian of _____ give permission to the Woolley Institute for Spoken-Language Education (WISE) to use my child's photo and video on public social media channels, as well as promotional outlets.

_____ _____

Signature of Parent/Guardian Date Signed

Woolley Institute for Spoken-Language Education

2305 Montevallo Road, Birmingham, AL 35223

(205)728-5480 Fax 205-649-6464

CONSENT FOR RELEASE OF INFORMATION

As the parent/guardian of _____, I hereby consent for the release of
FULL NAME OF CHILD

information _____ TO and/or _____ FROM the speech-language pathologists of the **Woolley Institute for Spoken-Language Education (WISE)** and its affiliates for the coordination of services for my child. Specifically, I consent for the following persons and/or entities to consult with **Woolley Institute for Spoken-Language Education (WISE)**, via all means of communication, regarding my child's status in the areas of:

____ COMMUNICATION

____ BEHAVIOR

____ HEALTH/MEDICAL

____ ACADEMICS

NAME(S) OF PERSONS/ENTITIES: _____

_____

_____

By signing below, I understand that this consent will remain effective for one year from the date of signing and that I may withdraw this consent at any time.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

Confidentiality and HIPAA Disclosure

This form describes the federal confidentiality laws outlined by the Health Insurance Portability and Accountability Act (HIPAA). All information shared between you and the **Woolley Institute for Spoken-Language Education (WISE)** during intake, evaluation, treatment, and counseling sessions will be held in strict confidentiality according to federal regulations. Federal law dictates that a copy of this information is provided to all clients before the initiation of evaluation or therapy services.

Definitions:

a. *Protected Health Information (PHI)* refers to any information in your health file that may identify you, such as your name, address, diagnoses, and medical and/or treatment history.

b. *Treatment* refers to time spent with you in treatment, evaluation, and consultation to discuss questions and concerns. This also includes time spent managing your treatment and other services related to your healthcare, including consulting with another healthcare provider such as your general practitioner (GP) or another speech pathologist. [OR RELEVANT SERVICE PROVIDER]

c. *Payment* refers to filing for reimbursement for your therapy services, such as when PHI must be disclosed to insurance companies to obtain payment or determine eligibility or coverage. Requested documents may include diagnostic codes and reports, types of therapy services provided, times and dates of sessions, therapy progress, description of impairment, case notes, and summarizations.

d. *Health Care Operations* refer to activities related to the performance and operation of the Woolley Institute for Spoken-Language Education, such as quality assurance and improvement, audits, administrative services, accounting, case management, and coordination of care.

e. *Use* applies only to activities within the private practice of the Woolley Institute for Spoken-Language Education such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you or your PHI.

f. *Disclosure* applies to activities outside of the private practice office of the Woolley Institute for Spoken-Language Education such as releasing, transferring, or providing access to information about you to other parties.

g. *Authorization* is your written permission to disclose confidential health information. All authorizations to disclose must be signed for on a specific, legally required form.

Uses and Disclosures with Authorization for Treatment, Payment, and Healthcare Operations

Protected Health Information (PHI) may be used or disclosed for treatment, payment, and healthcare operation purposes as defined above given your written authorization. You may revoke all such authorizations at any time, provided that each revocation is in writing. Revocation will not apply to a) authorizations already acted upon, b) authorizations obtained as a condition of obtaining insurance, disability, or worker's compensation coverage, c) a court ordered or third-party referral in which you are not legally defined as the client.

Uses and Disclosures without Authorization

Protected Health Information (PHI) or client information may be used or disclosed without your written consent only in the following circumstances:

a. *Mandated reporting of child abuse*: In the event that the Woolley Institute for Spoken-Language Education has reasonable cause to believe a minor or elder may be abused or neglected, there is an obligation to report this belief to the appropriate legal authorities.

b. *Mandated reporting of adult and domestic abuse*: In the event that the Woolley Institute for Spoken-Language Education has reasonable cause to believe an individual protected by state law has been abused, neglected, or financially exploited, there is an obligation to report this belief to the appropriate legal authorities.

c. *Serious threat to health or safety*: In the event that the Woolley Institute for Spoken-Language Education learns through client interaction or records that there is a specific threat of imminent harm, or risk of physical or mental injury against yourself or another individual, the company is obligated to disclose this information to protect yourself and/or others from harm.

d. *Oversight agencies*: Reporting of PHI to oversight agencies for activities authorized by law, including licensure, certification, and disciplinary actions is required.

e. *Court and judicial proceedings*: If you are involved in a court proceeding and requests for records of your diagnostic or treatment records are made, this information is privileged under state law and must not be released without a court order. This privilege does not apply if you are being evaluated by a third party or where the evaluation is court ordered. You must be informed in advance in this case. PHI may also be released directly to you upon request.

f. *Worker's compensation*: In the event of a worker's compensation claim in which speech pathology evaluation and treatment is relevant, PHI may be disclosed as authorized by and to the extent necessary to comply with laws relating to worker's compensation and other similar programs established by law that provide benefits for work-related injuries or illness without regard to fault.

g. *Professional consultation*: The Woolley Institute for Spoken-Language Education may consult with other professionals in order to aid client treatment and progress without written authorization only if information discussed does not reveal any identifying information covered und
er PHI.

h. *Minors and guardianship*: Parents and legal guardians of non-emancipated minor clients have the right to access the client's records and discuss evaluation and treatment with the Woolley Institute for Spoken-Language Education.

Patient Rights

a. *Right to request restrictions*: You have the right to request restrictions on certain uses and disclosures of PHI, but the Woolley Institute for Spoken-Language Education is not obligated to honor this request.

b. *Right to receive confidential communication by alternative means or at alternative locations*: You have the right to request and receive confidential documentation and communications of PHI by alternative means or alternative locations. For example, you may request to have your documentation sent to a separate address for additional privacy.

c. *Right to inspect and copy***:** You have the right to inspect and/or obtain a copy of your PHI collected by the Woolley Institute for Spoken-Language Education for as long as these records are maintained by the company.

d. *Right to amend:* You have the right to request an amendment of your PHI collected by the Woolley Institute for Spoken-Language Education for as long as these records are maintained by the company.

e. *Right to an accounting:* You have the right to receive an accounting of all disclosures of PHI.

f. *Right to a paper copy:* Documents may be exchanged between you and the Woolley Institute for Spoken-Language Education electronically. The Woolley Institute for Spoken-Language Education will make every reasonable attempt to keep this information protected, including password protection of electronic documents and secured webpages. However, information transmitted via email or fax may not be encrypted. You may request to obtain paper copies of documentations or alternative means of contact such as mail or telephone, instead of electronic communications.

Company/Therapist Duties

a. The Woolley Institute for Spoken-Language Education and its contractors, employees, and directors are required by law to maintain the privacy of PHI and to provide clients with a notice of its legal duties and privacy practices with respect to HIPAA and PHI.

b. The Woolley Institute for Spoken-Language Education reserves the right to change privacy policies and practices as described in this notice but is bound to abide by the terms in effect until you are notified of any changes.

Complaints

If you are concerned that the Woolley Institute for Spoken-Language Education has violated your privacy rights or disagree with a decision made by the Woolley Institute for Spoken-Language Education about your records, please contact the company in writing at 2305 Montevallo Road, Birmingham, AL 35223.

The law also provides that you may send a written complaint to the Secretary of the U.S. Department of Health and Human Services (DHS). This address will be provided to you by the Woolley Institute for Spoken-Language Education upon request.

Effective Dates of Privacy Policies

This notice will go into effect on March 1, 2020.

The Woolley Institute for Spoken-Language Education agrees to limit the uses and disclosures of confidential client information as defined by Alabama Law and the ethical recommendations put forth by the American Speech-Language-Hearing Association (ASHA). [OR OTHER SIMILAR BODY]

The Woolley Institute for Spoken-Language Education reserves the rights to change the terms of this notice and make new policies effective for all PHI information maintained. In the event of a policy change to client confidentiality, the company will provide you with a revised notice in person or via mail if requested by you in writing.

By signing below, I acknowledge that I have been provided with a copy of the Woolley Institute for Spoken-Language Education confidentiality policies as outlined by federal, state, and local regulations including Alabama state law and HIPAA. I have read, or have had read to me, this document in its entirety. I acknowledge and agree to the outlined policies on client confidentiality and understand their meanings and ramifications.

Printed Name: _____

Signature: _____

Date: _____