Lauren Eudoxie, CCC-SLP, LLC

95-1063 Kelakela St.
Mililani, HI 96789
Phone (808) 421 9607
leudoxie@gmail.com
NPI: 1811494339

SPEECH-LANGUAGE PATHOLOGY INTAKE FORM

Today's Date: _____

Name: _____ Date of Birth:_____

Address:_____

E-Mail:_____

Phone: _____ Phone2:_____

Parent/Guardian Names: _____

Child lives with both parents? Yes No Primary language spoken in home:_____

Pediatrician: _____ Phone: _____

Referral Source: _____

Previous evaluations (list): _____

Therapy to date (list): _____

Describe present problem: _____

Who noted present problem? _____ When? _____

What is your child's reaction to the problem? _____

How does the family react to the problem? _____

Has there been any significant change in last six months? Yes No

If yes, what? _____

How well is your child understood by: (i.e., what percentage of the time)

Mom: _____ Dad: _____ Younger siblings: _____ Older siblings: _____

Other children: _____ Extended family: _____ Unfamiliar adults: _____

Describe what it is like to have a conversation with your child: _____

_____

_____

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PRENATAL/BIRTH HISTORY

Full Term: Yes No If no, how many weeks? _____

Birth Hospital: _____

Illnesses or accidents during pregnancy: _____

Use of alcohol, tobacco or medications during pregnancy: _____

Birth weight: _____ Delivery: Vaginal Cesarean Breech Feet First

Other unusual conditions that may have affected pregnancy or birth? _____

MEDICAL HISTORY

Please check if your child has had any of the following (and if so, at what age):

Seizures ☐ _____ High fevers☐ _____ Measles ☐ _____ Mumps ☐ _____

Chicken pox ☐ _____ Whooping cough ☐ _____ Diphtheria ☐ _____ Croup ☐ _____

Pneumonia ☐ _____ Tonsillitis ☐ _____ Meningitis ☐ _____ Encephalitis ☐_____

Rheumatic fever ☐ _____ Tuberculosis ☐ _____ Sinusitis ☐ _____ Chronic colds ☐ _____

Enlarged glands ☐ _____ Thyroid ☐_____ Asthma☐ _____ Heart trouble☐ _____

Explain any checked items here: _____

Are immunizations current? Yes No Current general health:

**Has your child had any earaches/ear infections? Yes No Please explain here: _____

Allergies? (Describe) _____

Any other serious or recurrent illnesses? _____

Any operations? _____

Any accidents? _____

Any medications? (Past)_____ (Current) _____

Vision problems? Yes No Treatment: _____

Hearing difficulties: Yes No Treatment: _____

Dental problems? Yes No Treatment: _____

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DEVELOPMENTAL HISTORY

Age when child: (If you cannot remember specific time, please indicate if it occurred at the expected time or if it was delayed)

sat up alone _____ crawled _____ walked _____ toilet trained _____ dressed self _____

tied shoes _____ fed self independently _____ Weaned from bottle/breast _____

Is the child left or right handed? Left Right Able to use: open cup spoon straw

Any difficulty: Swallowing: Yes No Chewing: Yes No Drinking: Yes No

Blowing: Yes No Drooling: Yes No Food allergies: Yes No List:_____

Favorite Foods:_____

Aversive Foods (if any): _____

Attention span-for self-directed activities: _____ Adult-directed:_____

Eating and sleeping patterns:_____

Does your child respond typically to: Light? Yes No Sound? Yes No People? Yes No

Does your child: Play with others? Yes No Who? _____

Eat and sleep well? Yes No Cry appropriately? Yes No Laugh? Yes No

Make wants/needs known? Yes No How? _____

Does your child show unusual behavior (explain)?_____

LANGUAGE DEVELOPMENT

Age when your child spoke first word: _____ combined words: _____ spoke in sentences:_____

What was your child's first word(s)? _____ first sentence?_____

Which sounds (if any) are incorrect? _____

How many words can your child say? (list if fewer than fifteen) _____

How long are your child's sentences? _____

Does your child have any difficulty understanding you? (describe) _____

Does your child have difficulty following directions? (describe) _____

Any speech or hearing problems in the immediate or extended family (explain)? _____

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SOCIAL DEVELOPMENT

Names and ages of siblings: _____

Other adults living in the home: _____

Moves prior to age 10: _____

Relationship with peers: _____

Number of regular playmates: _____ Ages: _____ Genders: _____

Activities shared with parents and siblings: _____

How does your child handle: Frustration? _____

Conflict? _____ Separation:? _____

Regular responsibilities: _____

Favorite places: _____ people: _____ toys: _____

snacks: _____ activities: _____ TV programs: _____

What motivates your child most? _____

What discipline methods work best? _____

SCHOOL HISTORY

Child's Current School and Grade: _____

Child's performance educationally: _____

Receiving special services at school: _____

How does your child's teacher describe his/her performance? _____

Has the teacher expressed any concern? Yes No If so, what? _____

OTHER

What do you hope to have happen as a result of this evaluation? _____

What are your goals for you child? _____

Does the report need to be sent to specific agencies? Yes No Where? _____

Anything else you would like us to know? _____

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Speech and Language Clinical Contract

About the Service:

- Our services include screening, assessment, therapy and consultation of speech and language delays and disorders.
- Personal information, screening results and therapy notes will be kept secure and locked in a filing cabinet within the therapist's home, abiding to privacy and confidentiality regulations.
- You child's treatment program is important. The therapist will work with you to ensure that the best goals are chosen for your child.
- No guarantees can be made about your child's progress or outcomes during therapy. If you have concerns regarding progress please speak to your therapist first. If you have further concerns you can contact Lauren Eudoxie directly.
- Please be aware of your child's hearing ability. Speak to your therapist if you have any concerns. If your child wears hearing aids and/or glasses, please ensure they are available and working for therapy sessions.
- If you wish to videotape or take photos of any sessions, please let you therapist know and it can be arranged.
- If you want information regarding your child's communication shared with your child's teacher or other professionals please ensure you have completed the authorization for releasing/obtaining information.

Your Child's Appointment(s): _____

- Appointments will be booked one month in advance
- These times have been reserved for your child. Your child is to attend all scheduled sessions.
- Parent/guardian attendance/participation is requested during each therapy session.
- If you have any questions about therapy or your child's therapy program, please ask during session. A meeting or phone call can be arranged if more time is needed.

Home Practice:

- You are asked to complete home practice exercise that are discussed with you. This encourages your child's progress and makes therapy more effective.
- Our role as a Speech-Language Pathologist (SLP) is to demonstrate ways to improve your child's speech, language and communication. Your role is to ensure that these strategies are used in day-to-day interactions.

Cancellation of Appointments: Call or Text your therapist directly or Lauren Eudoxie at (808) 421 9607

- Please provide as much notice as possible (ideally 48 hours) when cancelling your child's appointment.
- Each child will be given two (2) free cancellations (with a minimum of two hours' notice) in a given year. Additional cancellations with notice will be charged $80.
- Cancellations without notice will be charged $80 collected from parent.
- Please be aware that you can decline to continue services from Lauren Eudoxie, CCC-SLP, LLC at any time for any reason.

_____ parent/guardian initials

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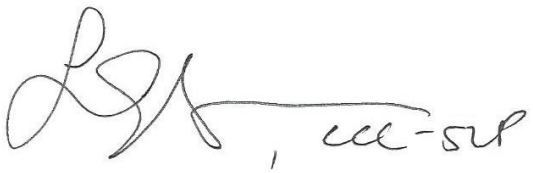
PLEASE KEEP THIS CONTRACT FOR FUTURE REFERENCE

I have read and agree to the above information. I am providing consent to accept Speech-Language Pathology services by Lauren Eudoxie, CCC-SLP, LLC under the aforementioned guidelines:

_____ _____

Parent/Guardian signature **Date**



_____ _____

Lauren Eudoxie, CCC-SLP, LLC M.SpeechPathStudies **Date**

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PATIENT INFORMATION

_____ _____ _____
Last Name First Name MI

_____ _____ _____
Date of birth M/F Social Security Number

_____
Address (Street, City, State, Zip Code)

_____ _____ _____
Contact number #1 Contact number #2 E-mail address

INSURANCE INFORMATION

_____ _____ _____
Primary Insurance Name Policy Number (SSN) Group Number

_____ _____ _____
Policy Holder's Name Policy Holder's Date of Birth Relationship

_____ _____ _____
Secondary Insurance Name Policy Number Group Number

_____ _____ _____
Secondary Policy Holder's Name Policy Holder's Date of Birth Relationship

_____ _____
Referring Physician Primary Care Manager

AUTHORIZATION

I _____ , authorized the release of any protected health information to process claims and request payment of benefits to Lauren Eudoxie, CCC-SLP, LLC. I agree to be responsible for payment of any deductibles, co-payments, cost share and/or services provided not covered by my insurance.

Patient's or Authorized Person's signature: _____ Date:_____

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Health Insurance Portability and Accountability Act (HIPPA)
Notice of Privacy Practices for Protected Health Information

This notice describes how medical information about your child as a client may be used and disclosed and how you can obtain access to this information. Please review this information carefully.

Protected Health Information (e.g., demographic information, medical records, physical or mental health conditions, or any information that is reasonably believed to identify your child in any way), whether collected electronically, on paper, or orally, must be kept confidential. Federal law requires me to comply with the terms of this notice or face penalties for the misuse of **Protected Health Information**.

I could use and disclose your child's **Protected Health Information** in the following circumstances:

- Treatment: I may disclose your child's **Protected Health Information** to a referring doctor or specialist to provide, coordinate and/or manage services between one or more health care providers. They may provide me with similar **Protected Health Information**.

- Payment: I require reimbursement for services provided. Your child's **Protected Health Information** may be disclosed to obtain payment. Disclosure for payment includes determining eligibility for services under the plan, disclosures to and/or billing services or collection agencies and utilization reviews.

- Health Care Operations: I may be required to evaluate the quality of services I am providing at Lauren Eudoxie, CCC-SLP. This may include quality assessments, auditing functions and cost management analysis.

- Appointment reminders: I may contact you to provide you with appointment reminders or information about medical treatment alternatives or other health-related benefits and services that may be of interest to you.

I may be required to disclose your child's **Protected Health Information** without your authorization in a variety of circumstances. These include but are not limited to: controlling communicable diseases, reporting child abuse, neglect or domestic violence situations, in response to judicial or administrative orders for law enforcement purposes and for certain research purposes. In these situations a record will be kept that will explain my attempt to obtain consent or the reason why consent was not obtained.

I am required to disclose your child's **Protected Health Information** upon your request and to the US Department of Health and Human Services (DHHS) when they are determining whether or not I am in compliance with federal law.

If you believe your child's privacy rights have been violated, please file a written complain to me. You may also file a complaint with the Office for Civil Rights of the DHHS. Your complaint must be: a) in writing b) name the company and describe the acts or omissions you believe to be in violation of the privacy rules, c) be filed within 180 days of when you knew or should have known that the act or omission complained of occurred unless the time limit is waved by the DHHS. The complaint may be sent to: Office of Civil Rights, US Department of Health and Human Services, Region IX, 50 United Nations Plaza, Room 322, San Francisco, CA 94102.

Please feel free to contact me directly if you have any further concerns about this notice.

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Health Insurance Portability and Accountability Act (HIPPA)
Notice of Privacy Practices for Protected Health Information

Receipt and acknowledgment of Notice

I am the parent/legal guardian of _____, (_____).
Client name Date of Birth

I hereby acknowledge receipt of the Notice of the Privacy Practices for Protected Health Information for Lauren Eudoxie, CCC-SLP, LLC with respect to this client. I understand that if I have any further questions or concerns regarding the Notice of Privacy Practices for **Protected Health Information** I can contact Lauren Eudoxie, M.SpeechPathStudies, CCC-SLP.

_____ _____
Signature Date

_____ _____
Printed Name Relationship to client

☐ Parent refuses to acknowledge receipt

_____ _____
Signature Date

_____ _____
Printed Name Relationship to client