Welcome to Little Chatterbox Speech, Language, and Hearing Solutions, LLC

Thank you for choosing Little Chatterbox to help meet your child's communication needs. We realize there are many options from which to choose and we appreciate the opportunity to assist you with this important process.

The attached New Client Enrollment packet includes important information about our practice including insurance, financial, and privacy policies. Please take time to fill out as much information as possible regarding your child's developmental history as this information can be vital to the direction of the therapy plan. We understand that these forms can be time consuming; however, it is important that we have as much information as possible prior to your first visit so that in order to provide the best possible service for your child. If your child has had any recent evaluations completed by other health professionals (neurologist, psychologist, IEP, etc.), please bring copies of these with you or kindly fax them to us in advance.

Completed form packets may be faxed to 769-251-5623, e-mailed to us at mlindseyslp@littlechatterboxspeech.com, or mailed to 506 Kate Lofton Drive Brandon, MS 39047. Please feel free to call or e-mail with any questions or concerns regarding this packet.

We look forward to meeting you and your child!

Sincerely,

____

Michael T. Lindsey, CCC-SLP

Today's Date:

Speech and Language Intake

Name:______________________________________Date of Birth: ______________________________

Address: ____

E-Mail:____

Phone:_____________________________________Phone 2: __________________________________

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?__________________________________

If so, 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:_____________________________

____

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?____________Current general health: ____________________

**Has your child had any earaches/ear infections? Y N Please explain here: ____________

____

Allergies? (Describe) ____________________

Any other serious or recurrent illnesses? ____________________

Any operations? ____________________

Any accidents? ____________________

Any medications? (Past) ____________ (Current) ____________

Vision problems?____________________Treatment:____________________

Hearing difficulties:____________________Treatment:____________________

Dental problems?____________________Treatment: ____________________

Other Medical History: ____________________

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?____________Able to use: open cup spoon straw

Any difficulty? (Y/N) Swallowing:_____________Chewing:________________Drinking:____________

Blowing:_______________Drooling:_______________Food allergies: _______________________________

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?_____________Sound?___________People? _____________

Does your child: Play with others?____________Who?____

Eat and sleep well?_______Cry appropriately?________Laugh?____________Smile? __________________

Make wants/needs known? _____________ 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)?____________________

____

____

SOCIAL DEVELOPMENT

Names and ages of siblings: ____

Other adults living in the home: ____

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 educational performance : ____

Receiving special services at school: ____

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

____

Has the teacher expressed any concern? If so, what? ________________________________

OTHER

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

Does the report need to be sent to specific agencies?______Where?____________________________

____

Anything else you would like us to know?

____

____

CONTACT INFORMATION

At times we may need to contact you for appointment reminders or other concerns. Please complete only the items below that you authorize as a method of contact. Note: Home address, one phone number and one e-mail address are required.

Address ____

Home Phone______________________Ok to leave message: Yes No

Mother's Cell Phone________________Ok to leave message: Yes No

Mother's Work Phone_______________Ok to leave message: Yes No

Mother's Email____

Father's Cell Phone_________________Ok to leave message: Yes No

Father's Work Phone________________Ok to leave message: Yes No

Father's Email____

Please select your preferred contact method (one only) for each item listed below:

Appointment Reminders: Mother's Email Father's Email Phone

Other Correspondence: Mother's Email Father's Email Phone

INSURANCE/PAYMENT INFORMATION

Insurance Carrier: ____

Billing/Claim Address: ____

Benefit/Eligibility Phone Number: ____

Policyholder Name: ____

Plan/Program Name: ____

ID Number: ____

Policy Group or Number: ____

NOTE: Copies of the policyholder's driver's license and insurance card may be made at the first appointment.

Assignment of Benefits (insurance patients only):

I____________________________, authorize the release of any payment and medical information necessary to process me or my family member's insurance claim and related claims. I hereby authorize payment directly to Little Chatterbox Speech, Language, and Hearing Solutions, LLC of the insurance benefits otherwise payable to me for all professional services.

________________________ __________
Signature of Policyholder Date

PARTY RESPONSIBLE FOR PAYMENT

Personal Information:

Name:___________________________DOB:_____________SSN:_____________________

Address____

Phone: ____

Employer Information:

Company Name: ____

Company Address: ____

Contact Number: ____

POLICIES AND PROCEDURES

Appointments

If you must cancel an appointment that you have scheduled, please call immediately. Except under emergency circumstances, all appointments cancelled with less than 24 hour notice will be subject to a $35 service fee. In the event that you arrive late for your appointment, we will do my best to see you, however the appointment may be shortened due to time constraints; the full session fee still applies. Please note that most insurance companies will not reimburse for missed appointments and you will remain responsible for these charges. Please do not bring any child to the clinic that does not have an appointment with us (e.g., siblings), unless you have discussed this in advance.

Confidentiality

Your privacy is very important to us. We strongly recommend that you review the *Notice of Privacy Policy* for important details regarding policies for maintaining confidentiality. In particular, you should be aware that we will only contact you via means that you have specifically authorized in your new client paperwork. If you would like us to exchange information with persons other than yourself, an *Authorization for Release of Information* form must be completed. This form can be downloaded from the client forms section of the website.

Fees

We will always inform you of the charges prior to providing any type of clinical service. A schedule of fees can be obtained from our office at any time. Fees apply to various types of services including direct client contact (clinic based or offsite), phone consultations, travel, and consultation with other professionals.

Payment

The person who completes the Party Responsible for Payment section is responsible for payment of all services rendered. In most cases, payment is due at the time services are rendered unless you have made other arrangements in advance. For children scheduled for individual therapy without a parent present, payment should be made in advance or be sent with the child (services will not be provided otherwise). Accounts more than 30 days overdue will be subject to a $20 late fee and 5% interest charge. Accounts more than 60 days overdue will be sent to collection. For clients seeking third-party reimbursement, please be aware that you are ultimately responsible for the payment of services rendered. In the event that your insurance carrier denies payment (including recoupment) or does not remit payment within 45 days, the client will be responsible for payment of all services rendered. We may at times provide discounts or fee waivers for families with extenuating circumstances; however, it is the client's responsibility to ensure that acceptance of such fee reductions will not adversely affect third-party payment obligation.

Health Insurance

We participate with some insurance companies, but not all. In the event that we do not accept your insurance, we will be happy to provide you with the necessary paperwork to assist you in seeking reimbursement for out-of-network provider services. Please also be advised that many health insurance plans have limited coverage for speech-language pathology services. It is recommended that you contact your insurance company to discuss the limits of your coverage.

Termination of Services
In the event that you do not keep your financial obligations to Little Chatterbox Speech, Language, and Hearing Solutions, LLC and remain delinquent on your account for more than 60 days, services will be suspended until payment is received. Services may also be terminated if it is determined that continued participation will be a detriment to the child or their family.

Health Policy
Your cooperation is required in order to maintain a healthy environment. A child must be temperature-free for 24 hours before returning to therapy. If your child has vomiting and/or diarrhea, he/she should not return to therapy until 24 hours have passed since the last episode of the same.

Children will not be seen if any of the following is present:

- Too ill or uncomfortable to function in the therapy setting
- Continual runny nose
- Thick or discolored nasal discharge
- Excessive sneezing or coughing and mucus-producing cough
- An elevated temperature

NOTICE OF PRIVACY POLICIES

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.

Our Legal Duties

State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. Little Chatterbox Speech, Language, and Hearing Solutions, LLC is required to abide these policies until replaced or revised. Little Chatterbox Speech, Language, and Hearing Solutions, LLC have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place. The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by the law as private information. Little Chatterbox Speech, Language, and Hearing Solutions, LLC respect the privacy of the information that you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information

Information about you may be used by the personnel associated with Little Chatterbox Speech, Language, and Hearing Solutions, LLC for diagnosis, treatment planning, treatment, and continuity of care. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is the policy of Little Chatterbox Speech, Language, and Hearing Solutions, LLC not to release any information about a client without a signed release of information except in certain emergencies or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

Abuse

If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

In the Event of a Client's Death

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child or spouse's records.

Professional Misconduct

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records unless it is determined that access would have a detrimental effect on the therapeutic relationship, or on the client's physical safety or psychological well-being.

Other Provisions

When payment for services is the responsibility of the client, or a person who has agreed to providing payment and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the time-frame, and the name of the clinic or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, summaries or copies of the entire clinical record. Only the minimally acceptable amount of information will be released to accommodate such requests.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within the practice or by outside sources specializing in (and held accountable for) such procedures.

Communications with the client outside the clinic setting will only occur as authorized by the client. When it is necessary to contact the client via telephone, messages will not be left on voicemails (or with persons other than the client or the client's legal guardian) unless Little Chatterbox Speech, Language, and Hearing Solutions, LLC has received written authorization to do so.

Your Rights

- You have the right to request to review or receive your medical files. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is $.25 per page, plus postage.

- You have the right to cancel a release of information by providing Little Chatterbox Speech, Language, and Hearing Solutions, LLC a written notice.

- You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them.

- You have the right to request that information about you be communicated by other means or to another location.

- You have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

- You have the right to know what information in your record has been provided to whom.

- You have the right to request a copy of this notice.

Complaints

If you have any complaints or questions regarding these procedures, please contact me. I will get back to you in a timely manner. If you believe your privacy rights have been violated, complaints should also be directed to Little Chatterbox Speech, Language, and Hearing Solutions, LLC. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201. There will be no retaliation for filing a complaint with Little Chatterbox Speech, Language, and Hearing Solutions, LLC or the Office of Civil Rights.

PATIENT RIGHTS

As a recipient of services at Little Chatterbox Speech, Language, and Hearing Solutions, LLC, we would like to inform you of your rights. Below is a description of each of your rights. If at any time you feel your rights have been violated, please contact Little Chatterbox Speech, Language, and Hearing Solutions, LLC and ask to speak with me.

- You have the right to refuse or terminate services at any time for any reason. Your participation in services is voluntary.

- You have the right to submit complaints or suggestions at any time. Little Chatterbox Speech, Language, and Hearing Solutions, LLC will fully investigate any complaints and seriously consider any suggestions you have for improving the services we provide.

- You have the right to information regarding the cost of services. Little Chatterbox Speech, Language, and Hearing Solutions, LLC will always inform you of charges before we provide a service. A schedule of fees can also be obtained from our office at any time.

- You have the right to privacy. Please see our Notice of Privacy Policy for information regarding certain limits to confidentiality and how your protected health information will be used.

- You have the right to know under what conditions we will terminate our services. Please refer to Little Chatterbox Policies and Procedures document for this information.

- You have the right to be informed of any changes in our policies. You will always be notified in the event that we change a policy that is relevant to the services we provide you.

CONSENT/PAYMENT FORM

This form must be completed before services can be initiated. If the client is under the age of 18 years, the form must be signed by all legal guardians.

Consent for Treatment

I hereby attest that I have voluntarily applied for and entered into treatment, or give my consent for the minor or person under my legal guardianship, at Little Chatterbox Speech, Language, and Hearing Solutions, LLC. I understand that I may terminate these services at any time.

Receipt of Policies and Procedures

I hereby attest that I have received a copy of Little Chatterbox Speech, Language, and Hearing Solutions, LLC's Policies and Procedures, including payment policies, and have read, understand and consent to be bound by its content.

Receipt of Patient's Rights

I hereby attest that I have received a copy of the Patient Rights notice, have read, and understand its content.

Receipt of Privacy Policy and Consent for Disclosure of Health Information

I have been provided a copy of Little Chatterbox Speech, Language, and Hearing Solutions, LLC's Notice of Privacy Policies detailing how my medical record may be used and disclosed under Federal and State law. I understand that as a part of Little Chatterbox Speech, Language, and Hearing Solutions, LLC's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity (i.e., insurance, emergency, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax and e-mail only to appropriate parties. I fully understand and accept the terms of this Consent and acknowledge the receipt of the Privacy Notice. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I understand that by refusing to sign this consent or revoking this consent, Little Chatterbox Speech, Language, and Hearing Solutions, LLC may refuse to treat me. I further understand that Little Chatterbox Speech, Language, and Hearing Solutions, LLC reserves the right to change its privacy policies and will provide me with a copy of any revised notice.

Name of Patient (Printed):____

By signing below, you are attesting to the accuracy of the above statements including all consents and authorizations implied therein. A copy of this agreement is available upon request.

________________________________ ____________
Patient Signature (18 years or emancipated) Date

For minors:

________________________________ ____________
Legal Guardian Signature Date

________________________________ ____________
Legal Guardian Signature Date