The Speech House, LLC

Laying the foundation for communication

CLIENT INFORMATION

Patient:_____DOB:_____**S**ponsor's SSN: _____

Last First Middle

Address_____

Street City ZIP

Cell Phone: _____ Text Y or N Email: _____

Parent/Guardian Information (if applicable)

Name 1:_____DOB: _____

Last First Middle

Address_____

Street City ZIP

Cell Phone: _____ Text: Y or N Email: _____

Name 2:_____DOB: _____

Last First Middle

Address_____

Street City ZIP

Cell Phone: _____ Text: Y or N Email: _____

Physician

Primary Care Physician: _____ Phone:_____

Primary Dentist:_____ Phone: _____

Referring Physician:_____ Phone: _____

Initial _____

The Speech House, LLC

Laying the foundation for communication

Patient Name:_____ **Date of Birth:** _____

Insurance

Primary Insured**:**_____DOB: _____
Primary Insurance Carrier:_____Phone Number: _____
Billing/Claim Address:_____City:_____State:_____
ID #:_____Group #: _____
Secondary Insurance: _____
Policyholder Name:_____DOB:_____
Phone Number:_____Billing/Claim Address:_____
City:_____State:_____ Zip:_____

Policy Group or #:_____Group #: _____

Assignment of Benefits (insurance patients only):
I_____, authorize the release of any payment and medical information necessary to process my or my family member's insurance claim and related claims. I hereby authorize payment directly to The Speech House of the insurance benefits otherwise payable to me for all professional services.
Signature of Responsible Party:_____Date:_____

Payment Contract

Applicable to Self/Private Pay and Insurance Copays

Responsible Party: _____
Relationship Party : Self_____Parent_____Other (specify) _____
Preferred payment option:

_____I hereby acknowledge and agree to pay treatment fee balances at the time of service (cash or check).
_____I hereby authorize The Speech House, LLC, to use Autobooks weekly in order to keep my/my child's account balance current with the below listed credit card information.
_____I hereby acknowledge and agree to pay treatment fee balances monthly (cash, check, credit card (below listed).
_____I understand that I have the right to cancel my Autobooks with 10 day written notification provided to The Speech House, LLC..

Card Information

_____Mastercard _____Visa _____Debit _____AmEx

Card Holder Name: _____
I understand this information is kept private and confidential and is protect by HIPPA regulations under patient confidentiality.
Signature of Responsible Party or Patient:_____ Date:_____

Card Number:_____ **Exp. Date:**_____ **CVV:**_____

Initial _____

The Speech House, LLC

Laying the foundation for communication

POLICIES AND PROCEDURES

CANCELLATION POLICY

If you must cancel an appointment, please call/text the office at least 24 hours in advance. Except under emergency circumstances and acute illness, all appointments cancelled with less than 24 hours notice may be subject to a $25 service fee. There will be ONE "failure to cancel" courtesy provided. After three (3) no-shows, the patient will be put on probation. The three (3) no-shows may result in termination of service and notification to the referring physician. If you arrive late for your appointment, we will do our best to see you; however, the appointment may be shortened due to time constraints.

TERMINATION OF SERVICES

Due to the importance of continuity of care, regular attendance to appointments is necessary. If excessive appointments are missed and/or canceled, The Speech House reserves the right to discharge services. In the event that you do not keep your financial obligations to The Speech House and remain delinquent on your account for more than 30 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.

The Speech Language Pathologist reserves the right and professional judgement to discontinue services.

CONFIDENTIALLITY

Your privacy is very important to us. I 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.

HEALTH POLICY

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

Please do not bring sick or febrile family members to the clinic.

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.

Strict CDC guidelines are followed for COVID-19.

Initial _____

The Speech House, LLC

Laying the foundation for communication

SIBLINGS

If you need to bring siblings to the clinic, please have them use their inside voices in the waiting room and be respectful of our space, so as not to disturb others in session or waiting in the shared space.

HEALTH INSURANCE

We participate with some insurance companies, but not all. If The Speech House is not contracted with your insurance, we will be happy to provide you with a superbill 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. We recommend that you contact your insurance company to discuss the limits of your coverage.

FEES

The person who completes the **Party Responsible for Payment** section is responsible for payment of all services rendered. Payment is due at the time services are rendered unless you have made other arrangements in advance. **Accounts more than 30 days overdue will be subject to a $20.00 late fee and 5% interest charge. Accounts more than 90 days overdue will be sent to collections**. For clients seeking insurance reimbursement, please be aware that **you are ultimately responsible for the payment of services rendered. If your insurance carrier denies payment (including recoupment) the client will be responsible for payment of all services rendered.**

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 The Speech House. 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 The Speech House'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.

TELETHERAPY

Teletherapy services are offered for both children and adults. It is used as a primary service mode as well as a substitute when clinic visits are not possible due to various factors, including but not limited to inclement weather, unexpected change to your work schedule, transportation difficulty and illness (quarantine).

Initial _____

The Speech House, LLC

Laying the foundation for communication

RECEIPT OF PRIVACY POLICY AND CONSENT FOR DISCLOSURE OF HEALTH INFORMATION

I have been provided a copy of The Speech House'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 The Speech House'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, The Speech House may refuse to treat me. I further understand that The Speech House reserves the right to change its privacy policies and will provide me with a copy of anyrevised notice.

PHOTOCOPY AUTHORIZATION

I permit a photocopy of this consent form as if it were an original executed consent.

Name of Patient (Printed):_____Date:_____

Patient Signature (if over 18 years or emancipated): _____Date:_____

For minors- Legal Guardian Signature:_____Date: _____

CONSENT TO AUDIO OR VIDEO RECORDING

I consent to allowing this speech therapy session to be recorded via audio or video. I understand the purpose of this recording is to provide assessment points and tools of measurement.

I have been advised it will not be released for use in any public material or presentation.

Patient Signature (if over 18 years or emancipated):_____Date

For minors- Legal Guardian Signature:_____Date_____

Initial _____

The Speech House, LLC

Laying the foundation for communication

Child's Name:_____Date of Birth: _____

Parent/Guardian Completing Form:_____

Child lives with both parents? Yes____No_____If no, with whom does the child live?_____

Primary language spoken in home:_____Secondary language: _____

Previous speech therapy evaluations (list): _____

Other therapies to date (list): _____

Describe present problem/chief complaint:

_____

_____

_____

_____

_____

_____

Who noted present problem?_____When did it start? _____

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

_____

How does the family react to the problem? Is He / She aware? _____

_____

Has there been any significant change in last six months in regard to the chief complaint/problem or overall?_____If so, what? _____

_____

_____

Initial _____

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

Parents:_____Younger siblings:_____Older siblings:_____Grandparents: _____

Other children:_____Extended family:_____Unfamiliar adults: _____

Provide an example of a conversation with your child: _____

_____

_____

PRENATAL/BIRTH HISTORY

Full Term: Yes_____No_____If no, how many weeks? _____

Birth Hospital:_____State: _____

Illnesses or accidents during pregnancy:_____

Use of alcohol, tobacco, or medications during pregnancy: _____

_____

Birth weight:_____ Delivery: Vaginal_____Cesarean_____ N.I.C.U.- Yes_____No_____

Breech (Feet First)_____Head First_____Respiratory Issues at birth: _____

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_____Chicken pox_____Whooping cough/Diphtheria _____
Croup_____Pneumonia_____Tonsillitis_____Meningitis_____Encephalitis_____
Rheumatic fever_____Tuberculosis_____Sinusitis_____Chronic colds_____
Enlarged glands_____Thyroid_____Asthma_____Heart trouble_____Other_____

Explain any checked items here: _____
_____

Diagnosis:_____

Are immunizations current? Y / N Flu: Y / N COVID: Y / N (Circle)

Have you traveled outside the U.S. within the past 60 days? _____

If so, where? _____

Initial _____

The Speech House, LLC

Laying the foundation for communication

CURRENT GENERAL HEALTH

Has your child had any earaches/ear infections? Yes____No____Eustachian (P.E.) tubes? _____

If chronic, list frequency here:

_____

Allergies? Yes_____No_____If Yes, describe_____

Hearing difficulties: Yes_____No_____
Has your child had hearing screening assessment? Yes_____No____Date_____Pass_____Fail_____

Any other serious or recurrent illnesses? _____

Any operations? Yes_____NO_____If yes, please describe._____

_____

Any accidents/falls involving trauma to the head?

_____

Any medications? If Yes, please list along with dosage and # per day (a preprinted list is also acceptable)

_____

_____

Vision problems? Yes____No____If Yes, Past_____Current:_____Glasses:_____Eye Surgery:_____

Please describe:_____

Dental problems? Yes_____No_____If Yes, please explain _____

Other Medical History not listed above:_____

_____

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 independently_____tied shoes _____

Is the child left or right handed? _____

Attention span-for self-directed activities:_____Adult-directed:_____
Bedtime:_____Does your child sleep well? _____

Does your child respond typically to: Light?_____Sound?_____People?_____
Does your child: Play with others?_____Who? _____

Cry appropriately?_____Laugh?_____Smile?_____Get upset easily? _____

Initial _____

Have difficulty calming?_____Have difficulty sitting still?_____Sleeping issues?_____Have eating issues?_____Have attention issues?_____Have difficulty transitioning from one activity to another?_____Perseverate on objects or activities?_____Have complicated routines for bed, bath, mealtime, etc._____Cover his/her ears in response to otherwise typical sounds/noises? _____

Have difficulty with daily living activities (tooth brushing, hair washing, etc.)_____Dislike having their hands dirty? _____

Make wants/needs known?_____Provide an example. _____

Does your child exhibit unusual behavior (explain)? _____

_____

FEEDING HISTORY

Difficulty latching to bottle or breast?_____Bottle/Nipple Type: _____

If so, please explain:_____

Fed self independently_____Weaned from bottle/breast_____

Able to use: open cup_____spoon_____straw _____

Any difficulty? Swallowing:_____Chewing:_____Drinking:_____Blowing: _____

Drooling:_____Orally Defensive:_____ If so, explain: _____

_____

Food Allergies:

_____

_____

Favorite Foods:

_____

_____

Aversive Foods (if any): _____

_____

LANGUAGE DEVELOPMENT

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

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

First sentence? _____

Initial _____

Which sounds (if any) are of concern? _____
How many words can your child say?_____(List if fewer than fifteen) _____

_____

How many words are your child's sentences?_____

Does your child have any difficulty understanding you?_____If yes, please describe: _____

_____

_____

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

_____
Any speech or hearing problems in the immediate or extended family (explain)? Has or does anyone receive services?

_____

SOCIAL DEVELOPMENT

Names and ages of siblings: _____

Other adults living in the home: _____

Number of moves prior to age 10:____Relationship/s 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?: _____

Unfamiliar People?: _____

How many minutes/hours of television does your child watch per day?_____Electronics?_____

What motivates your child most? _____

What discipline methods work best? _____

Initial _____

The Speech House, LLC

Laying the foundation for communication

SCHOOL HISTORY

Child's Current School / Daycare:_____Grade:_____

Child's performance academically: _____

Receiving special services (OT,PT,ST,SI) at school: Yes_____No_____If Yes, which services? Examples?

_____

Does your child currently have an IFSP or IEP? _____

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

Has the teacher expressed any concern? Yes_____No_____If so, explain: _____

_____

Family Medical History: _____

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

_____

_____

Anything else you would like us to know? _____

Initial _____