Speech 4 Kidz, Inc.

Patient Information Form **Date:** ____________

Child's Full Name:______________________________________ DOB:_____________Age:_______ Sex:_____
Child's Address:_________________________________City:_____________________State:_____Zip:________
Child's School/Daycare:____Phone:_______________________

Guardian Name (1):_________________________________Street Address:________________________________
City:___________________State:____Zip:___________Email:____
Home Phone:___________________ Work phone:______________________ Cell Phone: ____________________
Place of Employment:_____________________________________Occupation:______________________________

Guardian Name (2):_________________________________Street Address:________________________________
City:___________________State:____Zip:___________Email:____
Home Phone:___________________ Work phone:______________________ Cell Phone: ____________________
Place of Employment:_____________________________________Occupation:______________________________

Emergency Contact: ________________________ Relationship:_______________________ Phone: ___________

Referring Physician/Pediatrician (Name/Facility): ____
Physician Phone:_________________________________ Physician Fax:___________________________________

Primary Insurance
Policy Holder's Name: _______________________________ DOB: _____________ Relationship: _______________
SSN: ___________________Policy #: __________________________ Group #: ____________________________
Insurance Company:______________________________ Employer: _____________________________________

Secondary Insurance
Policy Holder's Name: _______________________________ DOB: _____________ Relationship: _______________
SSN: ___________________Policy #: __________________________ Group #: ____________________________
Insurance Company:______________________________ Employer: _____________________________________

Assignment of Payment

Authorized person's signature: I hereby assign the medical benefits to which I am entitled from private insurance and other health plans to Speech4Kidz, Inc. to release information necessary to secure payment. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize Speech4Kidz, Inc. to receive direct payment for therapy services rendered to my child.

Signed: ____ Date: ____________________________________

Speech 4 Kidz, Inc.

Release of Information Form **Date: ____________**

Child's Name:____ DOB:________________________________
Guardian(s):____
Address:______________________________________City:____
State:__________________Zip:___________Phone:____

- I hereby authorize any physician, clinic, hospital, institution or school to release medical and psychological information regarding my child, (Child's Name)__________________________to Speech4Kidz, Inc.. I understand that this information is to be used for professional purposes only and that it will be regarded as confidential. I also authorize Speech4Kidz, Inc. to contact any persons or institutions to obtain any additional information regarding my child when necessary.

Signed___________________________________
(Guardian)

- I hereby authorize Speech4Kidz,Inc. to release therapy reports regarding my child (Child's Name)___________________, to any entity or professional associated with my child's care (physicians, any clinic, hospital, institution, insurance company, school, and other), with the exception of____.

Signed___________________________________
(Guardian)

- I, ______________________________, give my permission for Speech4Kidz, Inc. to photograph and/or videotape my child (Child's Name)___________________________, an use said photos/videos for promotional or teaching purposes.

Signed___________________________________
(Guardian)

Consent for Evaluation and Treatment

1. I authorize a therapist with Speech4Kidz to perform Speech-Language Therapy with (Child's Name)____. **Initials**_________
2. I authorize a student to be present in the room during therapy sessions for observation purposes. **Initials**_________
3. I authorize Speech4Kidz to text appointment changes or reminders to the following number ___________________________ or email____**Initials**__________
4. I understand it is my responsibility to contact my insurance to understand my copay, deductible and limits of my benefits. I am aware I will be held responsible for costs that exceed my plan. **Initials**_________
5. I understand it is my responsibility to inform the office immediately of any changes to address, insurance coverage, and general physician/pediatrician. Failure to do so could lead to claim denials for insurance. **Initials**_________

____ _____________________________________

Guardian Signature Relationship to Patient Date

Speech 4 Kidz, Inc.

Appointments and Cancellation Policy

In order to maintain optimal progress and insurance eligibility for your child, we take attendance very seriously. Regular attendance is a must for your child to achieve the goals his/her therapist has set for them. Although we do not require you to join in therapy sessions, we ask that you do not leave the premises without your child. Unforeseen circumstances can cause disruptions in our schedule as well as unnecessary anxiety for your child.

Cancellations:

Please be courteous and inform us promptly if you are unable to attend an appointment. If it is necessary to cancel, we require that you call a minimum of four hours in advance of your scheduled time. You may call our office or contact your therapist directly.

No-Shows:

A patient is considered a no-show when they miss their appointment without canceling within four hours of their scheduled appointment or arriving too late to receive therapy. Patients who are not at daycare when the therapist arrives to provide therapy are also considered a no-show and will be required to be seen in our clinic. No-shows disrupt the therapist's schedule and the child's progress toward meeting his/her goals, therefore you will be required to pay $30 for each no-show. Two no-shows will result in the child being discharged from our practice. If you wish to resume therapy after being discharged for non-compliance, you will be placed on a waiting list and your original appointment day(s)/time(s) will not be guaranteed. We understand that special circumstances arise and we will evaluate those cases as needed on an individual basis.

We encourage you to discuss realistic appointment needs with your therapist so that your child's goals can be planned for accordingly. We ask that you only schedule appointments that you are certain you can commit to. Please discuss desired schedule changes with your therapist immediately.

I, ___________________________, have read and understand the above appointment and cancellation policy.

Signature: ____ Date: _________________________________

Speech 4 Kidz, Inc.

Patient History

Personal Information:

Please complete the following information for your child.

First Name:_________________________________Last Name:_______________________________________
Nickname:__________________________________Sex:______ DOB:_______________Age:_____________

Referral Source:
Parent Concerns Pediatrician ENT Case Worker CDSA Other:_________________________

Who does child live with?
Both Parents Foster Parent(s) Adoptive Parent(s)
Single Parent (which one?)__________________________ Other:____________________________

Child's Race/Ethnicity:
Caucasian Hispanic African American Native American Asian Other:__________________
Primary Language Spoken in Home:
Englilsh Spanish Other:___________________
Siblings?

Name	Age	Sex	Speech/Language/Developmental Disorders?

Birth and Medical History:

Are there any notable issues during pregnancy? Yes No
If yes, please explain:

Was your child premature (<36 weeks)? Yes No If yes, how many weeks?___________

Has your child had any of the following?

Yes No Adenoidectomy
Yes No Allergies
Yes No Ear infections ** How many _______1-3 _______4 _______>7
Yes No PE tubes **when?___________________
Yes No Head injury
Yes No Seizures
Yes No Tonsillectomy
Yes No Vision problems **Glasses? yes/no
Yes No Does your child suck his fingers/thumb?
Yes No Does your child have a pacifier? **How often? ___________________________?

Does your child have any previous psychological, medical, or other diagnosis?

Diagnosis	Approximate Onset Date

Does your child take daily medications?

Medication	Amount/Frequency

Is this your child's first speech/language evaluation? Yes No

If no, when and where was previous was previous?________________________________

Recommendations:________________________________

Does your child have an IFSP/IEP? Yes No

How often is speech received at school (# of days/minutes per week)?________________

Developmental Milestones

When did your child use first words? (approximate month) ________________________

When did your child put two words together? (approximate month) __________________
Please list any developmental delays. I.e. rolling over, sitting up unattended, crawling, walking, etc.

Does your child…
Choke on food or liquids? Yes No
Put toys/objects in his/her mouth? Yes No
Brush teeth? Yes No
Know his/her name when called aloud? Yes No
Retrieve/point to common objects when requested (cup, shoes)? Yes No
Follow simple directions ("come here", "get your shoes")? Yes No
Correctly respond to yes/no questions? Yes No

How does your child communicate? Check all that apply:

Body language/facial expressions
Sounds (vowels/grunts) along with pushing/pulling and/or pointing
Single words
2-4 words combined
>4 words combined

Other:________________________________

Is your child's speech difficult to understand? Yes No *If yes, please explain:

Do you feel your child has a speech and/or language problem? Yes No *If yes, please explain:

Behavioral Characteristics:

Most of the time your child is…

Yes No Cooperative
Yes No Attentive
Yes No Agreeable to new activities
Yes No Happy
Yes No Easily frustrated
Yes No Makes good eye contact
Yes No Easily distracted
Yes No Destructive/aggressive
Yes No Withdrawn
Yes No Stubborn

Additional Feedback:

Please explain any other concerns or information that you feel will be helpful for the therapist when evaluating your child.