The House Of Speech Therapy, LLC

Speech and Language Therapy Services

W: (843)-970-0372 C: (202)-304-3971 F: (843)-376-1848

Email: info@thespeechtoolbox.com

www.thehouseofspeech.com

NEW CLIENT INTAKE FORM

**Please sign and date the top of each page included in the intake form.*

PERSONAL INFORMATION

Client's Legal Name_______________________________ **Date of Birth**: ___________________________ **Age**: ____________ Male: ____ Female: _____ **Primary Care**: ____________________________

Legal Guardian: __________________________________

Please check if it is okay to leave a message **Yes No**

Home Ph:________________________________ Cell Ph: _______________________________________

Work Ph: ________________________________ Best number to reach you at: ____________________

Email: ___________________________________ Physical Address: _______________________________

City, State, Zip: ____________________________ Occupation: ___________________________________

Employer: _______________________________________

Name of Primary Care Physician or Pediatrician and Fax Number:

____

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Who does the client reside with?
____

Please list name and contact phone number other authorized individuals (to have access to information):
____

INSURANCE INFORMATION (please fill out ALL areas)

Primary Insurance: ______________________________

Secondary Insurance: ____________________________

Policy Number: _________________________________

Group Number: _________________________________

Claims Address: ________________________________

Phone Number: _________________________________

Insured's Name: ________________________________

Insured's DOB: _________________________________

Responsible party SSN**: ___________________________**

*****Please attach or email a copy of the medical insurance card***

Please initial the following statement:

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________ I DO NOT HAVE ANY OTHER INSURANCE COVERAGE FROM ANY OTHER SOURCE OTHER THAN MENTIONED ABOVE.

EMERGENCY MEDICAL RELEASE

In the event medical attention is required for your patient while on the premises of The Speech Tool-Box, LLC we need your authorization to implement treatment. Please read and sign the statement below.

As legal guardian of ____________________________, I give my permission for The Speech Tool-Box, LLC to contact emergency personnel in the event of a medical emergency.

_______________________________________ ______________________________

Parent/Legal Guardian Signature Date

EMERGENCY CONTACT

NAME: ____

PHONE: ____

RELATIONSHIP:______________________________________

MEDICATION/ALLERGIES/CONDITIONS

Medications (Include prescription drugs, over the counter meds, vitamins, and homeopathic medications):

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____

Allergies/Reactions:
____

Diagnoses (Any known medical diagnosis or medical condition, with dates of diagnosis if known):

____

HISTORY FORM

Please answer the questions to the best of your ability and in as much detail as possible. Please add any information that you feel is important but is not covered on this form.

General History

Client's Name: _________________________ Nickname? _______________________ DOB: _____________

Current concerns:

____

What are your primary goals for therapy?
____
____
____

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____

Has the client previously received occupational, physical, or speech therapy? To address what concerns? Please include where, when, and for how long:

____

Is the client currently receiving any of these therapy services? Please list providers, locations, and days/times:

____

Pregnancy & Delivery (For Children or Teens only)

Did the client's mother have any illnesses or complications during pregnancy or delivery? Please describe:

____

____

Was the client premature? **YES** **NO**

Born at how many weeks gestation: _______ Birth Weight: ________

Did the client require any medical procedures before, during, or after birth? Please describe:

____

Developmental History (For Children or Teens only)

Please indicate at what age each major milestone was reached:

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Sitting up by self: ________ Crawling: __________ Walking: _____________

First word: ___________ Two words together: _____________

What was their first word? _______________________

What was their first phrase? ______________________

When did you first become concerned about your child's development?

____

Feeding (For Children or Teens only)

Did the client have any feeding problems as an infant? Please describe:

____

Was the client bottle fed or breast fed and for how long?

____

Did the client have any colic or reflux issues?

____

Describe the client's current eating habits and typical intake:

____

____

____

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____

Medical History

Please describe illnesses, hospitalizations, or surgeries that the client's has had and when they occurred:
____
____
____

Is there a family history of speech-language or other developmental delays?
____

____

Has the client had a neuropsychological evaluation? **YES NO**

If yes, date of most recent evaluation: ________________

Name of neuropsychologist: ________________________

Social History & Living Situation

Please describe the client's living situation (and any recent changes):
____

Siblings' names and ages(For Children or Teens only) :

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____

If your child was adopted, please answer the following questions:

Age of adoption: ___________

Is the client aware of adoption? **YES NO**

Previous home experiences prior to adoption:____

Educational History Grade: ___________________________

Name of school: ________________________________ Teacher: ___________________________

What kind of classroom (e.g., regular ed, special ed, life skills, pull-outs, etc.): ______________________________

Does your child have an IEP? **YES NO**

What services does your child receive at school through the IEP?

____

Names of any school therapists?

____

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Hearing & Vision

Has the client had his/her hearing tested? When? **YES NO _________________________**

What were the results? ____

Has the client had any ear infections? **YES NO _____________________________________**

Please list number if known: _______________

Did your client ever have tubes placed in his/her ears? **YES NO**

When? ____

Has the client had his/her vision tested? **YES NO** What were the results?

____

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Does the client wear glasses or hearing aids? **YES NO** For what condition?

____

AGREEMENT

The Speech Tool-Box, LLC offers Speech-Language Pathology services for patients referred to our practice. We are a licensed provider who develops individualized treatment plans to identify the services that will best suit your child's therapy needs. We will also work with your primary care practitioner to coordinate your care. Following the initial assessment visit(s), we develop a specific plan of care (POC) along with goals and objectives.

PHOTO PERMISSION

Please initial the following OPTIONAL statements:

______ I give permission for photographing/videotaping the client for the purposes of treatment, education, and documentation.

______ I give permission for photographing/videotaping the client to be used for advertising, and/or brochure.

EMAIL PERMISSION

Please initial the following OPTIONAL statement:

______ I give permission to The Speech Tool-Box, LLC to correspond with my client s legal guardians and care team via

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email regarding treatment, documentation, and home programming. I understand that The Speech Tool-Box, LLC email is encrypted internally; however, once an email is sent externally, correspondence may potentially be intercepted by an outside party.

AUTHORIZATION AND CONSENT FOR EVALUATION, TREATMENT, AND OPERATIONS:

Please initial the following statements:

______ I hereby give The Speech Tool Box, LLC permission to evaluate and treat my patient, and I understand there will be written, oral, and electronic communication between care providers/physicians, insurance companies, and The Speech Tool-Box, LLC staff.

I understand that state representatives for the purpose of insurance certification or licensing and quality assurance may review my client's records. I understand that all practices of confidentiality will be followed in use of the information gathered.

____ ___________________________

Parent/Legal Guardian Signature Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA): I acknowledged that I have viewed, read, and understand the HIPAA Policy and have been informed of my rights as a client's parent/guardian.

_______________________________________ ______________________________

Parent/Legal Guardian Signature Date

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CANCELLATION POLICY

The Speech Tool-Box, LLC strives to provide the best therapy services possible. In order to ensure optimal use of valuable therapy time, please discuss schedule changes at the end of your appointment with your therapist. An email and/or text should be sent to confirm time from both parties. We understand occasional changes are necessary due to illness, vacations, etc. Please contact us within 24 hours of a scheduled appointment if you need to cancel or reschedule that appointment. This allows for clients to reschedule into additional openings therapists may have. For Monday morning appointments, we ask to be notified no later than Sunday. Three (3) no-shows consecutive or inconsecutive (e.g. the therapist arrived at the location for the session with no answer) may lead to discharge.

In the case that the Speech-Language Pathologist is required to cancel and/or reschedule the session or multiple sessions, the sessions will be made-up as discussed and decided between the caregiver/parent(s)and the treating Speech-Language Pathologist.

Summer: Please note that due to services being provided year-round, there may be a mandatory closure of the clinic/halt of speech therapy services for two (2) consecutive weeks during the summer.

Please review and initial all statements below:

______ I understand it is my responsibility to communicate with Elan Hutchinson, owner of the Speech Tool-Box, LLC and/or the treating Speech-Language Pathologist of any schedule changes or appointment cancellations via email and/or text message.

______ If a therapy session is not canceled prior to an appointment time or is missed without any notice, this missed

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appointment is counted as a no-show (e.g. not home at the time of the appointment). Three (3) total no-shows may lead to discharge of services by the Speech-Language Pathologist. If the client is private pay, the cost of the session will still be charged.

______ We require an 80% attendance rate and may need to remove the patient from the therapist's schedule if efforts are not made to maintain this rate. Note: We calculate attendance quarterly and, as a courtesy, will notify you if your percentage drops below the required 80%. We are happy to work out scheduling problems with you. Please let us know if you are experiencing a problem with your current schedule. If therapy needs to be canceled for an extended time, (such as for an extended trip), we will hold your therapy spot for up to three weeks. We will then place you on the information list and will fit you back in the schedule as soon as we can.

I hereby understand the above cancellation policy and agree to abide by it.

____ _______________________

Parent/Guardian Date

QUALITY ASSURANCE & COMPLAINT RESOLUTION

Should you or the client experience a situation that requires the attention and resolution of a Supervisor and/or Manager, please contact our practice either in writing or by phone. A member of our management team will interact with you to reach a resolution of any identified situation where our quality of service has been compromised. We use such situations to alert us to improvements we can make to better serve all our clients.

PATIENT STATEMENT OF AGREEMENT

THE HOUSE OF SPEECH
THERAPY

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My signature below signifies that I have read and understand this client agreement for The Speech Tool-Box, LLC to provide me Speech-Language Pathology services. I agree to the terms in this client agreement and intend to comply with them to the best of my ability. I understand that if I fail to follow the terms of this agreement, I could be discharged from service.

______________________________________ ______________________________

Parent/Legal Guardian Signature Date

As your therapist, you can expect us to:

1. Begin and end your appointments in a timely manner.

2. Inform you of the goals targeted and the progress made during each session.

3. Provide strategies and ways for you to address goals at home to increase carryover.

4. Assist you in any way we can, from brainstorming ideas to help make your families' lives easier at home to talking with school therapists, etc.

5. Keep anything you share with us confidential.

6. Provide the best therapy we possibly can.

7. Receive courteous and friendly help when scheduling appointments etc.

8. Providing notice of need to reschedule an appointment. If you have any questions about the above information, please don't hesitate to ask us. We are here to help you! I have read and understand the above Clinic Etiquette and agree to abide by it.

____ ______________________

Parent/Legal Guardian Signature Date