Children's Speech and Hearing Specialists, LLC

83 Cambridge Street
Burlington, MA 01803
Phone 781.365.0316 Fax 781.365.0386
www.childrensspeechandhearing.com

All information given in this form will be considered confidential

Today's Date: _____

CLIENT INFORMATION:

Name of Child: _____ Date of Birth: _____

Age of Child: _____ Place of Birth: _____

Child's Grade: _____ Child's Primary Language: _____

Sex of Child: _____

Child's Home Address: _____
(street)

_____
(city) (state) (zip code)

Home Phone: _____

Name of Person Completing Form: _____

Relationship to Child: _____

PARENT/GUARDIAN INFORMATION:

Parent/Guardian Name: _____ Relationship:_____

Age: _____ Education: _____

Occupation: _____

Home Address: _____

_____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Primary Language:_____

Email:_____

Parent/Guardian Name: _____ Relationship: _____

Age: _____ Education: _____

Occupation: _____

Home Address: _____

_____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Primary Language:_____

Email:_____

If parent(s)/guardian(s) cannot be contacted, notify in case of emergency:

1. Name: _____ Phone: _____

   Relationship to client: _____

2. Name: _____ Phone: _____

   Relationship to client: _____

SPEECH HISTORY:

Describe the child's speech and/or language difficulty: _____
_____
_____
_____
_____
_____

Are you aware of any factors that may be contributing to his/her communication difficulty? _____
_____
_____
_____
_____
_____
_____

If your child is unable to make his or her needs understood through speech alone, how does he or she communicate? _____

When was the difficulty first noticed? _____

By whom? _____

Where and when does your child seem **most** comfortable communicating and in what modality (speech, sign, picture support system)? _____

Where and when does your child seem **least** comfortable communicating and in what modality (speech, sign, picture support system)? _____

Do you believe your child is aware of his/her communication difficulty? _____

Has the child had any previous speech therapy? _____

If yes, where, when, and by whom? _____

Is the child currently receiving any speech therapy? _____

If yes, where, for how long, and by whom? _____

To the best of your ability, please list all professionals you have communicated with regarding your child's communication difficulty:

Name: _____ Profession: _____

Contact Information: _____
(phone) (email)

_____
(mailing address)

Name: _____ Profession: _____

Contact Information: _____
(phone) (email)

_____
(mailing address)

Name: _____ Profession: _____

Contact Information: _____
(phone) (email)

_____
(mailing address)

Name of school child attends: _____
(name) (street) (city)

School phone: _____

Classroom Teacher(s): _____

SIBLING INFORMATION:

Name Age Any Significant Medical/Educational History

_____
_____
_____

Do each of the siblings live in the same home as the child? _____
_____
_____

Do any of the child's siblings have any communication difficulties or did they in the past? _____
_____
_____
_____
_____

Are any other languages spoken/signed in the home? _____

_____

Does your child have playmates of his/her own age? _____

Does he/she happily play with other children? _____

_____

_____

_____

At what age did schooling begin? _____

Has your child repeated any grades? _____

Is your child reading? _____ If yes, please describe their reading abilities: _____

_____

_____

Does your child enjoy school? _____

What does your child like **most** about school? _____

What does your child like **least** about school? _____

Additional comments/information: _____

_____

_____

_____

_____

MEDICAL/INSURANCE INFORMATION:

Primary Care Physician (PCP) Name: _____

PCP Phone: _____

Insurance Provider: _____

Subscriber and Policy Number of Client: _____

Insurance Phone Number: _____

Reason for Referral: _____

_____

_____

_____

Please list any medical issues (allergies, seizures, mobility, vision, hearing, etc.): _____

_____

_____

_____

Does your child take any medication? (please list) _____

_____

_____

Does your child wear glasses? _____ If yes, how often and for what reason? _____

_____

If Client has hearing loss, please provide an updated audiogram. *Please also detail the following:*

Type of Hearing Loss (Conductive , Sensorineural, Mixed): _____

Is Hearing Loss Bilateral _____ or Unilateral _____?

Degree of Hearing Loss: _____

Date of last hearing test: _____ Place of last hearing test: _____

Please list childhood disease and approximate age of illness: _____

_____

Does your child have a history of any of the following:

Tonsilitis: _____ Frequent colds: _____

Earache: _____ Ear Infections: _____

High fevers: _____

Was Client born prematurely? _____ If yes, please state Weeks of Gestation _____

Pregnancy Complications? (e.g., illness or unusual event during pregnancy)_____

_____

_____

_____

_____

Was labor and delivery normal? _____

_____

_____

_____

_____

Weight at Birth: _____APGAR Scores: _____

Developmental Milestones: Please state the age at which the client reached the following developmental milestones:

Held head up: _____

Sat up unsupported: _____

Crawled: _____

Walked unassisted: _____

Fed self with spoon: _____

Dressed self: _____

At what age was child toilet trained? _____

Babbled: _____

Imitated sounds: _____

First word: _____

Followed one step directions: _____

Enjoyed listening to a story: _____

Told a simple story accurately: _____

Put two words together: _____

Put three words together: _____

Talked in sentences: _____

Has your child had any feeding difficulties? _____
_____
_____

Did you child suck his thumb or fingers or pacifier? _____ If yes, at what age did he/she stop? _____

Describe any developmental concerns (outside of speech and language) that you or another family member may have about your child: _____
_____
_____
_____
_____

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Credit Card Authorization Form

All information will remain confidential.

Cardholder Name: _____

Billing Address: _____

_____

Credit Card Type: _____ Visa _____ Mastercard ____ Discover

Credit Card Number: _____

Expiration Date: _____

Card Identification Number (last 3 digits located on the back of the credit card): _____

Amount to Charge: $ ____90.00____ (USD)

I authorize Children's Speech and Hearing Specialists to charge the agreed amount listed above to my credit card provided herein. I agree that I will pay the cancellation fee in accordance with Client Policy Terms and Conditions that were provided and signed by me. In the event of any disputes, I agree that I am responsible for coverage of any chargeback fees.

Cardholder – Print Name, Sign and Date Below:

Signed: _____

Dated: _____

Name: _____

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HIPAA Consent

I give Children's Speech and Hearing Specialists my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review Children's Speech and Hearing Specialists Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that Children's Speech and Hearing Specialists has the right to change their privacy practices and that I may obtain any revised notices at Children's Speech and Hearing Specialists.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that Children's Speech and Hearing Specialists is not required to agree to the request. If Children's Speech and Hearing Specialists agrees to my required restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

_____ _____

Patient, parent or legal guardian Date

If signed by patient representative, state relationship to patient_____

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In order to bill for your child's services, the following information is needed:

1. Child's Primary Care Physician _____
   Telephone number _____

2. *Primary Policy Holder's* Name _____
   Primary Policy Holder's Date of Birth _____
   Primary Policy Holder's Employer _____
   Primary Policy Holder's Address _____
   (if different from child) _____

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Children's Speech and Hearing Specialists, LLC Payment Policy

INSURANCE:

We participate in local BCBS and HPHC Insurance Plans. If you are not insured by a plan we do business with, payment in full is expected at ***each*** visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

CO-PAYMENTS AND DEDUCTIBLES:

All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

CLAIMS SUBMISSIONS:

We will submit your therapy claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

COVERAGE CHANGES:

If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will be automatically billed to you.

NON PAYMENT

If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice.

MISSED APPOINTMENTS

Our policy is to charge for missed appointments not canceled within 24 hours. These charges are your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

_____ _____

Parent/Guardian Signature Date

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AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

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

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct Children's Speech and Hearing Specialists to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient(s): (name and contact numbers of individuals including parent, Pediatrician, school personnel etc)

1. _____
   _____
   _____
2. _____
   _____
   _____
3. _____
   _____
   _____
4. _____
   _____
   _____

Information to be disclosed: This authorization permits Children's Speech and Hearing Specialist's to disclose the following records pertaining to the patient's health care:

- ❑ All of my health information that Children's Speech and Hearing Specialists has in their possession, including information relating to any medical history, and any treatment received by me (evaluation results, treatment notes, progress notes)
- ❑ All of my health information described above except for the following: _____
- ❑ Only the following records or types of health information: (Insert dates of treatment, types of treatment or other designation.)_____.

Term: This Authorization will remain in effect:

- ❑ One full year from the date signed.
- ❑ Until the following event occurs:_____

Refusal to sign/right to revoke: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by Children's Speech and Hearing Specialists.

_____ _____
Signature of Patient Date

If Individual is unable to sign this Authorization, please complete the information below:

_____ _____ _____
Name of Guardian/Representative Legal Relationship Date

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CLIENT POLICIES

- If possible, please arrive 5 minutes prior to your session so that you have adequate time to get situated and your child can receive the full amount of therapy.
- Each session will consist of 50 minutes direct service and 10 minutes consultation so that we can answer any questions you may have and update you on your child's progress. In addition, we will provide you with suggestions on how to carry therapy techniques over into your everyday routines.
- If you have additional concerns that cannot be answered within the allotted therapy time, we would be happy to schedule a consultation session (via phone, email or in person) at rate of $25.00 per 15 minute increment.
- If your child is sick (has a fever of 100 degrees Fahrenheit or higher, or has vomited and/or had diarrhea within 24 hours) please do not bring him/her to the office for therapy. We will do our best to reschedule an appointment if requested.
- If you will be using insurance to pay for your child's therapy, it is your responsibility to obtain a referral as needed. If further services are warranted, we will request an extension of services from your insurance provider. It is then your responsibility to ensure that this request has been granted. Any services that have been rendered, but not covered by insurance, are your financial responsibility.
- Please let us know as soon as possible if you change insurance providers. It is your responsibility to obtain new referrals when changing insurance providers.
- **CANCELLATIONS:** Appointments require a 24-Hour Cancellation Notice. You will be personally charged the *full* session fee for **ANY** cancellation made with less than 24-Hours Notice **regardless of the reason.** Your insurance company will *not* pay for this charge. In the event of a cancellation without 24 hours notice, your credit card will automatically be charged for the session fee. Our telephone number has answering machine coverage: Monday appointments may be cancelled during the weekend.
- **ATTENDANCE:** Regular attendance is essential to the efficacy of treatment. Therefore, if your child misses more than 20% of scheduled sessions, we reserve the right to terminate services.
- **CONFERENCES:** Brief conferences of 10 minutes or less are part of the regular therapy process and no additional charges will be made. However, consultations that exceed this length of time with parents and/or professionals working with your child will be charged at a rate of $25.00 per 15 minute increment. These services include but are not limited to consultation by phone, email or in person, review of IEPs, attendance at IEP meetings, and advocacy services. Insurance providers ***do not*** cover such charges therefore it is the responsibility of the parent(s) to incur these costs.
- Co-payments are due at the time of your visit. If you would like to set-up prepayment options please contact the office and arrangements will be made.
- A late payment fee will be applied to payments not received within 30 days of due date. A $15 charge will be applied after 30 days, $20 after 45 days, and $25 after 60 days.
- We will return phone calls and emails as quickly as possible, but at least within two business days.
- We accept cash and checks for payment. We do not accept credit or debit cards except in the instance of late cancellation fees.
- A $30 fee will be charged for returned checks.

I have read and understood the above policies and agree to them.

_____ _____

Parent/Guardian Signature Date

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Authorization Waiver

I, _____, understand that Children's Speech and Hearing Specialists will initiate and provide speech therapy services for my child _____ regardless of the status of insurance authorization.

However, if at any time, Children's Speech and Hearing Specialists does not receive authorization/payment from my insurance provider, I agree that I, _____, am responsible for paying the treatment charges in full.

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed or treatment previously provided.

_____ _____

Patient, parent or legal guardian Date

If signed by patient representative, state relationship to patient_____