Intake Questionnaire

Patient's Name: _____ Date of Birth: _____

Parent/Guardian (1): _____ Phone Number: _____

Parent/Guardian (2): _____ Phone Number: _____

Email: _____ Home Address: _____

Primary Physician: _____ _____

Please describe your concerns regarding your child's speech and language: _____

_____

_____

When did you first notice these concerns? _____

What would you like to gain from this appointment? _____

_____

_____

Background:

Were there any complications with the pregnancy or your child's birth? ☐ Yes ☐ No

Has the child had any serious illnesses, injuries, or medical diagnoses? ☐ Yes ☐ No

Is your child taking any medications at this time? ☐ Yes ☐ No

Were your child's motor milestones (sitting, crawling, walking) delayed? ☐ Yes ☐ No

Were your child's communication milestones (babbling, talking) delayed? ☐ Yes ☐ No

Is there a family history of speech, language, or learning delays/disorders? ☐ Yes ☐ No

Please check if you have any concerns with your child's:

☐ Hearing ☐ Vision ☐ Eating ☐ Toileting ☐ Sleeping ☐ Other (explain)

If you have concerns or answered yes to any of these questions, please explain: _____

_____

_____

Who currently lives in the home (Please list sibling name/age)? _____

_____

What is your child's primary language: ☐ English ☐ Other: _____

Is your child exposed to any other languages? ☐ No ☐ Yes, _____

Education:

☐ Not in school ☐ Preschool ☐ Public/Private ☐ Homeschool ☐ Online ☐ Other (explain)

School: _____ District: _____Grade: _____

Does your child have an Individualized Education Plan (IEP) or 504 Plan? ☐ Yes ☐ No

If yes, in which area(s) does your child qualify for services:

☐ Communication ☐ Social/Emotional ☐ Motor ☐ Adaptive ☐ Cognitive ☐ Other

Please check if your child receives specialized instruction in any of these areas:

☐ Reading ☐ Writing ☐ Math ☐ English Language Learning (ELL) ☐ Other

Therapies:

Has your child ever had a speech/language evaluation? ☐ Yes ☐ No

If yes, when and where? _____

What were the results/recommendations? _____

Has your child ever received speech therapy? ☐ Yes ☐ No

If yes, when and where? _____

What goals were being worked on? _____

*Please bring a copy of current or previous evaluations, Individualized Education Plan (IEP), or any other outside records you feel would be useful for us to have.

Is there anything else you would like us to know about your child?

Privacy Practices

We are required by law to maintain the privacy of our patients' health information and to provide patients with notice of our legal duties and privacy practices with respect to your personal health information.

Use and Disclosures of your Personal Health Information

Except as outlined below we will not use or disclose your personal health information for any purpose unless you have signed a form authorizing the use or disclosure. You have the right to revoke the consent or authorization in writing unless we have taken any action in reliance on the consent or authorization.

We will make uses and disclosures of your personal health information as necessary for your treatment. We may also release your personal health information to another health care facility or professional who is or will be providing treatment to you. We will make uses and disclosures of your personal health information as necessary for payment purposes. For example, we may use your health information for purposes of preparing a bill to send to the entity responsible for payment; this may be you or an insurance company. We will use and disclose your personal health information for operations, which include clinician improvements, or as required by law.

With your approval we may disclose your personal health information to your family and friends involved in your care. This will require your written release and consent and will only be given to the designated individuals in your release.

Business Associates

Certain aspects of our services may be performed by contracts with outside persons such as accreditations, auditing, or legal services. At times it may be necessary for us to provide certain information from your personal health care information to allow for this service. In all cases we require these entities to safeguard the privacy of all information under the requirements of HIPAA.

Access to Personal Health Care Information

You have the right to copy and inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your representative. We may charge you for copying, mailing, and compiling the information.

Accounting and Disclosure of Your Personal Health Care Information

You have the right to receive an accounting of certain disclosures made by us of your personal health care information. All requests must be in writing and sent to Monroe Speech & Language Center, attention HIPAA Compliance Officer.

Disclosure of Health Information Restrictions

You have the right to request restrictions on certain uses and disclosures of your health care information. While we are not required to consent to your request as it affects health care operations, billings or as required by law, we will attempt to accommodate such requests. We retain the right to terminate an agreed to restriction if it becomes necessary to meet business operations such as health care delivery, billings, or as required by law.

If you believe your privacy rights have been violated you may file a complaint in writing with the HIPAA Compliance Officer (Kristi Tekel DBA Monroe Speech and Language Center; Jodie Hastings Speech Language Pathologist LLC; Brenda Ray, LLC; Jodie Nichols Speech Language Pathologist LLC).

Acknowledgement of Receipt of Notice

- ☑ I have received and read the above notice regarding my rights to privacy for my Protected Health Information.
- ☐ I give permission for my child's therapist to leave a detailed message (voicemail, text) if I cannot be reached.
- ☐ I give permission for my child's therapist to communicate with me via email. I understand that communications via email are not secure. Although it is unlikely, there is a possibility that information included in an email can be intercepted and read by other parties besides the person to whom it is addressed.

Please sign and date the form acknowledging you have received this Notice of Privacy Practices. This will be kept on file.

_____ _____

Signature of Parent/Guardian Date Signed

Office Policies

Attendance

- In order to make optimal progress, it is important to attend therapy sessions consistently. We require a 75% attendance rate each month in order for your child to remain on schedule. If your child falls below 75% attendance, we may take a break from therapy and your child will be placed back on the wait list.
- During summer months, our attendance and cancellation policies remain in effect. If your schedule dictates that your child cannot attend 75% of appointments, your child may have to take a break from therapy and go back on the wait list until you can consistently attend sessions.
- Please do not assume that we are closed on days that your child may have off from school. We are open during many of the typical school holidays and vacations. If you are unsure if we will be open or closed during a particular holiday, please call us or check with your child's therapist to confirm.

Late Arrivals

- If you are late to an appointment, the session will need to end at the usual time to allow the clinician to stay on schedule. If the clinician is running late for any reason, you will be given your full session time. Our staff regrets any inconvenience to your personal schedule and we will make our best efforts to maintain timeliness.

Cancellation Policy

- If you are unable to attend a speech therapy session, please notify your clinician at least 24 hours in advance. Please note that a "No Show" fee of $50.00 will be charged for late cancellations (with the exception of illnesses, emergencies, and inclement weather) or if you miss a scheduled appointment without notifying your clinician. This fee cannot be billed to insurance and you will be responsible for this "no-show" fee.
- Please use common sense when cancelling an appointment. If your child may be contagious or is clearly not feeling well, please keep your child home out of consideration for your child, the clinician, and other families. In general, if your child is too sick for school, they are too sick to come to therapy. Please notify your therapist as soon as possible if you need to cancel due to illness. If an alternate time is available, we will attempt to reschedule your child's appointment.

Billing/Fees for Service

Option 1 (Insurance):

☐ I would like my therapist to bill my private health insurance as the primary means of payment and have provided my insurance card to be copied and kept on file. I understand that therapists may not be registered with all insurance plans and not all services are covered benefits. I acknowledge that I am responsible for understanding my own insurance plan and the speech therapy benefits that it provides (including prior authorization, benefit limitations, benefit maximums, deductibles, coinsurance, and copayments). I will notify my child's therapist immediately of any changes in my health insurance plan or I may be subject to charges resulting from denied claims. If claims are denied as a result of changes/limitations in insurance coverage benefits, the private pay rate will be charged to me directly.

- Some insurance plans require prior authorization or a physician's referral before starting therapy sessions. I understand it is my responsibility to obtain these before my child's visit, or my insurance company may refuse to reimburse the cost for the visit.
- I understand that if I dispute a claim, or a claim involves a third party, and/or collection from the third party, my therapist will not negotiate with the third party for me. I am responsible to pay the bill on time, settle the dispute, and/or collect from the third party.
- **I assign to Kristi Tekel DBA Monroe Speech and Language Center; Jodie Hastings Speech Language Pathologist LLC; Brenda Ray, LLC; or Jodie Nichols Speech Language Pathologist LLC for all services rendered, all benefits to which I am entitled from private insurance and other health plans. I give my clinician permission to submit bills directly to my insurance carrier. I understand that I am responsible for all co-payment, deductible, co-insurance payments, and/or the cost of denied claims for services at the time of service and am financially responsible for any charges that are not paid by insurance.**

Option 2 (Private Pay):

☐ I will pay privately for services provided. The private pay rate of $_____ per _____ minute therapy session will be charged to me. For evaluations, the private pay rates vary apply depending upon the type of evaluation performed. The private pay rate for evaluation of Speech Production is $_____, and evaluation of Speech Production & Language Skills is $_____. I understand that payment is due at the time of service unless other arrangements have been made.

My signature below signifies that I have read and understand this client contract and authorize Monroe Speech Therapy to provide speech-language evaluation and/or speech therapy services to the above-named client.

_____ _____

Client/Parent/Guardian Signature date signed