



Speech Language Spot Client Information & Consent Form

Please print clearly, thank you.

PARENT'S INFORMATION

PARENT'S NAME _____
HOME ADDRESS _____
MAILING ADDRESS (IF DIFFERENT) _____
EMAIL _____
PRIMARY PHONE # _____ HOME OR MOBILE (CIRCLE)
ALTERNATE PHONE # (OPTIONAL) _____
PARENT'S OCCUPATION _____
PARTNER'S NAME _____
PARTNER'S DATE OF BIRTH _____
PARTNER'S OCCUPATION _____
EMERGENCY CONTACT NAME _____
EMERGENCY CONTACT PH# _____
WHO REFERRED YOU TO THIS PRACTICE? _____

CHILD'S INFORMATION

CHILD'S NAME _____ CHILD'S DATE OF BIRTH _____
CHILD'S SEX: M or F BIRTH WEIGHT _____ BIRTH PLACE: _____
CHILD'S HEALTH CARE PROVIDER(S): _____
CHILD'S PROVIDER'S PH# _____ FAX# _____
PREVIOUS THERAPEUTIC INTERVENTION:
OT: _____ DATE OF ASSESSMENT _____
PT: _____ DATE OF ASSESSMENT _____
SLP: _____ DATE OF ASSESSMENT _____

INSURANCE INFORMATION

MOTHER'S POLICY: BRAND _____ MEMBER # _____ GROUP # _____
CHILD'S POLICY: BRAND _____ MEMBER # _____ GROUP # _____

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Consent Agreement to be READ, INITIALED & SIGNED before the Speech Language Assessment/Treatment

____ I understand the following: The Speech Language Pathologist (SLP) is an allied health care provider and responsible for evaluating and recommending a care path to resolve or improve speech language development. A speech language assessment includes a detailed history of child, standardized and informal assessment tools, observations, and recommendations for management to improve and/or resolve speech and language related issues. All clients are provided with a written assessment report which includes detailed assessment findings, clinical impressions, strengths and weaknesses, prognosis, goal suggestions, applicable referrals and recommendations. The Speech Pathologist provides therapeutic intervention when warranted and based on availability. If the evaluating Speech Pathologist does not have availability to provide the therapeutic intervention, a referral will be provided to other Speech Pathologists, and it is the parents responsibility to contact them and schedule therapy. The client and the speech language pathologist each have responsibilities in this path. Resolution of a communication delay or disorder often takes several days or weeks and may require a change in the original recommended care path at some point.

____ Remaining in contact during the time following the Speech Language Assessment is crucial and considered an extension of your visit. You will have access to me via our private HIPPA compliant Parent Portal as well as text/email/phone to report progress and/or to communicate continued problems or concerns. **I understand it is my responsibility to call the Speech Pathologist with progress reports, questions or concerns.**

____ I understand any change from my physician's recommendations should be discussed with the physician. Health care issues of a medical nature MUST be discussed with a physician.

____ I understand a partial or follow-up visit is sometimes necessary. I understand that speech/language supplies and/or resources may be recommended as effective management of specific situations. Only effective resources will be recommended.

____ I hereby authorize the Speech Pathologist to release any information acquired in the evaluation and/or management of myself and/or my child to our health care providers, referring physician, referring allied healthcare provider, and/or our insurance company upon request. I understand the Speech Pathologist may contact my child's physician if the Speech Pathologist feels it is necessary to consult with the physician.

____ I have received a copy of this provider's Privacy Practices.

____ I understand this practice accepts **fee for service at time of service**. It is my responsibility to pursue reimbursement for lactation services from my insurance company. This practice does no billing for insurance reimbursement and is not a provider on any insurance plan. However, we do provide an itemized superbill and detailed instructions to submit for reimbursement. I understand that reimbursement is not guaranteed, but filing is suggested.

____ I give permission for information, photos and/or videos of my Speech Language visit to be used on social media or website for promotional purposes, and in speech language articles or studies for professional education.

Signature _____ **Date** _____

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