INTAKE FORM

Name: _____ Race/Ethnicity: _____
DOB/Age: _____ School/Grade: _____

GENERAL INFORMATION:

Child lives with: □ Both Parents □ Mother Only □ Father Only □ Grandparents □ Parent and Stepparent □ Foster Parents
□ Adoptive Parents □ Other _____

Physical Address: _____
Mailing Address if different: _____

Mother's Name: _____ Father's Name: _____
Preferred Phone: _____ Preferred Phone: _____
Email: _____ Email: _____

Other individuals living in the home including siblings: Age Sex Relationship to child

_____
_____
_____
_____
_____

Has your child ever received speech therapy? If yes, please explain and indicate where: _____
_____

Does your child currently receive special education services at a school? If yes, please explain: _____
_____

What are your main concerns for your child? _____
_____

What are your child's strengths? _____
_____

What are your child's interests? _____

COMMUNICATION/SWALLOWING:

Please list any concerns with your child's articulation skills (how your child says sounds and ability to be understood by others): _____
_____

Please list any concerns with your child's language skills (understanding what others say, communicating wants/needs, using correct grammar, knowing and use age-appropriate vocabulary): _____
_____

Please list any concerns with stuttering: _____
_____

Please list any concerns about your child's voice (pitch, quality, loudness, resonance): _____
_____

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130 Briarwood Circle
Sulphur Springs, TX 75482
903-243-0702

Please list any concerns with your child's eating or swallowing: _____

_____

PREGNANCY/DEVELOPMENT/MEDICAL:

Were there any problems before, during, or immediately after birth? If yes, please explain: _____

_____

Was the child carried to term? If no, at how many weeks gestation was the child born? _____

_____

Did the child have any difficulties immediately after birth? If yes, please explain: _____

_____

At what age did your child first do the following:

Produce first word: _____ Walk: _____

Produce two-word phrases: _____ Eat solid foods: _____

Speak in sentences: _____ Stop drinking from a bottle: _____

Crawl: _____ Stop sucking pacifier/thumb: _____

Please list any medications your child currently takes: _____

_____

Please list any known medical conditions: _____

_____

Please list any known allergies: _____

Has your child ever had his/her hearing checked? If so, when was the test and what were the results? _____

_____

Has your child ever had his/her vision checked? If so, when was the test and what were the results? _____

_____

Print Child's Name: _____ Print Parent/Guardian Name: _____

Date: _____ Parent/Guardian Signature: _____

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PATIENT NOTIFICATION OF PRIVACY POLICIES (HIPAA AUTHORIZATION)
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT YOUR PRIVACY RIGHTS

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Bubble Speech Therapy is dedicated to ensuring the privacy of your child's speech and/or language evaluation findings and course of therapy treatment. In serving our patients, we create records regarding treatment and services that are provided in order to have accurate information and ensure the appropriateness and efficiency of treatment services. Federal law requires us to strictly protect any personally identifying information on your child. This notice discloses our policies regarding the storage, use, and sharing of confidential patient information. **PLEASE REVIEW THIS NOTICE CAREFULLY**.

Bubble Speech Therapy is required by law to keep your health information safe. This information may include:

- Notes from your doctor, teacher, or other health care provider
- Your medical history
- Your test results
- Treatment notes
- Insurance information

A government rule requires that you get a copy of this privacy notice. This rule is called the Health Insurance Portability and Accountability Act, or HIPPA for short. We will ask you to sign a paper acknowledging that you have been given this notice.

How Your Health Information May Be Used or Shared

We may use your health information without your permission for the following reasons:

1. Treatment: We may share your information with doctors or other health care providers who care for you. For example, if your doctor orders speech therapy, we will share the results of our treatment with that doctor.
2. Payment: We may use and share information about the treatment you receive with your insurance company or other payer to receive payment for therapy services. This may include sharing important medical information. We may share information to:
   a. Get the insurance company's permission to start treatment
   b. Get permission for more treatment
   c. Get paid for the treatment you receive
3. Health Care Operations: We may use and share your health information to run the clinic and make sure all patients receive good care. For example, we may use your health information to:
   a. See how well our services are working
   b. See how well our staff is doing
   c. See how we compare to other clinics and private practices
   d. Make our services better
   e. Help others study health care services

Your health information may also be used or shared without your permission for:

- Abuse and Neglect: We may share your health information with government agencies when there is evidence of abuse, neglect, or domestic violence.
- Appointment Reminders: We will use your information to remind you of upcoming appointments. Reminders may be sent in the mail, by email, or by phone call or voicemail message. If you do not wish to get reminders, please tell your speech-language pathologist.
- As Required by Law: We will share your information when we are told to by federal, state or local law. We will also share information if we are asked by the police or courts.
- Government Functions: Your information may be shared for national security or military purposes. If you are a veteran, your information may be shared with the Office of Veteran's Affairs.
- Information About a Person Who Has Died: We may share information with the coroner, medical examiner, or a funeral director, as needed.
- Health-Related Benefits and Services: We may use your information to let you know of other services that might be of interest to you.
- Public Health Risks: We may report information to public health agencies as required by law. This may be done to help prevent disease, injury, or disability. It may also be done to report medical device safety issues to the Food and Drug Administration and to report diseases and infections.
- Regulatory Oversight: We may use or share your information to report to agencies overseeing health care. This may include sharing information for audits, licensure and inspections.
- Threats to Health and Safety: Your health information may be shared if it is believed that it will prevent a threat to your health and safety or the health and safety of others.
- Worker's Compensation: We will share your information with Worker's Compensation if your case is being considered as a work-related injury.

When Your Permission is Needed to Use or Share Your Health Information

You must give us your permission to use or share your health information for any situation that is not listed on this notice. You will be asked to sign a form, called an authorization, to allow us to share your information. You are allowed to take back this authorization, called revoking authorization, at any time. We will not be able to get the information back that we shared with your permission.

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Your Privacy Rights
You have the right to:

- Ask us not to share your information: You can ask us not to use or share your information for treatment, payment, or health care operations. You can also ask us not to share information with people involved in your care, like family members or friends. You must ask for limits in writing. We must share information when required by law. We do not have to agree to what you ask.
- Ask us to contact you privately: You can ask us to only contact you in a certain way or at a certain place. For example, you may want us to call you but not email. Or you may want us to call you at work and not at home. You must ask in writing.
- Look at and copy your health information: You have the right to see your health information and get a copy of that information at any time. You have the right to see treatment, medical and billing information. You may not be able to see or copy information put together for a court case, certain lab results, and copyrighted materials, such as test protocols.
- Ask for changes to your health information: You can ask us to change information that you think is wrong. You can also ask that we add information that is missing. You must ask us in writing and give us a reason for the change. We do not have to make the change.
- File complaints: You can file a complaint with us or with the government if you think that:
  - Your information was used or shared in a way that is not allowed
  - You were not allowed to look at or copy your information
  - Any of your rights were denied
- Get a paper copy of this privacy notice: You can get a paper copy of this notice at any time.
- Get a report of how and when your information was used or shared: You can ask us to tell you when your information was shared and who we shared it with. There are some rules about this:
  - You need to ask us in writing.
  - You must tell us the dates you are asking about and if you want a paper or electronic copy.
  - You may get information going back six (6) years, but it cannot be for earlier than April 14, 2003. This is the date when the government privacy rules took effect.

Who is Covered by This Notice
The people that must follow the rules of this notice are:

- All speech-language pathologists at Bubble Speech Therapy.
- Anyone who is allowed to add health information to your file, including students and other staff
- Any volunteers who may help you while you are at this clinic/private practice

Changes to the Information in This Notice
We may change this notice at any time. Changes may apply to information we already have in your file and any new information. Copies of the new notice will be available from our staff. The notice will have a date on the front page to tell you when it went into effect.

Complaints
You may file a complaint if you think we did something wrong with your information. You can complain to your regional office of the United States Office of Civil Rights. All complaints must be in writing. You will not get in trouble for filing a complaint.

Contacts
If you have any other questions about this notice or your privacy rights, please ask your speech-language pathologist.

I HAVE READ AND UNDERSTAND THE PRIVACY POLICIES DISCLOSED IN THIS NOTICE.

_____ _____
Parent/Guardian Signature Date

_____
Parent/Guardian Printed Name

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CONSENT FOR RELEASE OF INFORMATION

Child's Name: _____ Date of Birth: _____

I, _____ (Parent/Guardian) hereby grant Bubble Speech Therapy permission to communicate with the following person or agency:

Physician Name	Phone	Address

Bubble Speech Therapy may discuss and release to the person or agency information including but not limited to evaluation reports, treatment plans, progress notes and therapy documentation, previous medical history, as well as necessary verbal communication pertaining to the child. This information will be used for diagnostic and treatment planning purposes only. It is my understanding that this information will not be shared with any other entity without my prior knowledge. I further acknowledge that the use of this information is to ensure the best quality of care possible for my child.

_____ _____

Print Parent/Guardian Signature Date

_____

Parent/Guardian Printed Name

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PAYMENT POLICY

Bubble Speech Therapy is an out of network provider. Payment is due at time of service. Currently, Bubble Speech Therapy does not accept private insurance.

ATTENDANCE AGREEMENT & CANCELLATION POLICY

The parent/guardian agrees to bring the child to speech therapy at Bubble Speech Therapy at the agreed upon date/time. Bubble Speech Therapy requires at least a 24-hour notice for cancellation. Otherwise, you will be charged the full fee. Additionally, you will be charged full fee if you do not show up for a session. Please cancel if your child is running a fever, has gastrointestinal problems or runny nose/cough.

PARENT/GUARDIAN AGREEMENT

I, _____, parent/guardian of _____, have read and understood the above policies and agree to adhere to them. I understand that Bubble Speech Therapy reserves the right to terminate services if the payment policies and/or attendance and cancellation policies are not followed.

_____ _____

Parent/Guardian Signature Date

_____

Parent/Guardian Printed Name

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CREDIT CARD CHARGE AUTHORIZATION FORM

Please initial beside each statement below:

_____ The undersigned hereby authorizes Bubble Speech Therapy to charge the below-referenced credit card for services rendered and any related expenses. In addition, I understand my credit card will be charged if:

- I do not provide a different form of payment at time of service.
- Proper cancellation procedures are not followed as noted in the Policy forms.
- A check is returned for insufficient funds (fee of $30.00).
- At discharge, if an account balance remains, your credit card will be charged for unpaid services to discharge date.

_____ There will also be a $3.00 charge for every use of a credit card for payment.

I, the undersigned, further understand it is my responsibility to inform Bubble Speech Therapy of any changes to my credit card information including address, zip code, updated expiration dates, account numbers and security codes.

PLEASE PRINT CLEARLY

Check One: □ Master Card □ Visa □ Discover

Name on Card: _____

Card Number: _____

Expiration Date: _____

Security Code: _____

Billing Address: _____

Billing City: _____

Billing State: _____ Billing Zip Code: _____

BY SIGNING BELOW, I UNDERSTAND THAT IF MY BALANCE IS NOT PAID IN FULL WHEN PAYMENT IS DUE, THE ABOVE CARD WILL BE CHARGED FOR ALL PAYMENTS OWED TO BUBBLE SPEECH THERAPY.

_____ _____

Card Holder Signature Date

_____

Printed Name

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PERMISSION TO EVALUATE AND/OR PROVIDE THERAPY

Child's Name: _____ DOB: _____

Parent/Guardian Name: _____

Please complete the form below to grant permission and authorize a comprehensive speech and language evaluation, and/or treatment (as needed) for your child. Speech-language evaluations consist of standardized testing, informal and formal observations, and clinical judgment.

I, _____, authorize Bubble Speech Therapy, to evaluate and/or provide the necessary speech and/or language treatment/therapy/services to _____. Treatment is based upon the findings of the evaluation and the recommendations of the responsible speech-language pathologist.

Treatment will only be conducted after your therapist has spoken with you about the results of the evaluation and fees. A state-licensed and certified speech-language pathologist will administer the evaluation (including standardized evaluation tests, language samples, caregiver interviews, etc.). Your therapist will provide subsequent treatment, if needed, to the child. Results of the evaluation will determine a treatment/therapy course that will include the recommendations of the speech-language therapist and input from the parent.

_____ _____

Parent/Guardian Signature Date

_____

Parent/Guardian Printed Name

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