Welcome!

Thank you for choosing Therapy and Learning Center of GA, LLC. to help meet your child's communication and educational needs. We sincerely appreciate this opportunity, and we look forward to working with you and your child.

The attached New Client Paperwork packet includes important information about the practice. Please take time to fill out as much information possible regarding your child's developmental history, as this information can be vital to the direction of the therapy plan. We understand that these forms can be time consuming however, it is important that we have as much information as possible prior to your visit so that we may provide the best possible service for your child. If your child has any recent evaluations completed by other health professionals (psychologist, IEP, etc.), please bring copies of these with you or may email them to us in advance.

Our office policy is that you will need to place a credit card on file. This is because there is no "sign out desk" in the office and Amy, our director, handles the billing. The form is attached.

Sincerely,

Amy Squires, M.S.CCC-SLP
Speech and Language Pathologist
Director of Therapy and Learning Center of GA
GA License #: SLP008235
ASHA Certification#: 12132094

Milton Speech Pathology Therapy & Learning Center of GA

Speech Therapy Intake Form

Identifying Information:

Patient Name:_____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

E-mail:_____

Phone 1: _____ Phone 2: _____

Parent/Guardian Names: _____

Mother's Occupation: _____Father's Occupation:_____

Child lives with both parents? ☐ Yes ☐ No

Primary Language Spoken in Home: _____

Others living the home (names, ages, and relationship to patient): _____

_____

Referral Source:

Pediatrician:_____ Phone:_____

Reason for referral:_____

Previous evaluations (list): _____

Therapy to date (list): _____

Describe the present problem: _____

_____

Who noted the present Problem? _____ When? _____

How does the family react to the problem? _____

Have there been any significant changes in the last six months? If so, what? _____

Milton Speech Pathology Therapy & Learning Center of GA

Speech-Language-Hearing

Has your child ever received a speech evaluation/screening ? ☐ Yes ☐ No

If yes, where and when? _____

What were you told? _____

_____

Has your child ever had a hearing evaluation/screening? ☐ Yes ☐ No

If yes, where and when? _____

What were you told? _____

_____

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

If yes, where and when? _____

What was the focus of the therapy? _____

_____

Is your child receiving any other types of therapy? (Physical, Occupational, Vision, counseling, etc.) ☐ Yes ☐ No

If yes, please describe: _____

_____

How well is your child understood by others?_____

Describe what it is like to have a conversation with your child:_____

_____

_____

Is your child aware of, or frustrated by, any speech/language difficulties? _____

_____

Milton Speech Pathology Therapy & Learning Center of GA

Prenatal/Birth History

Full Term: ☐ Yes ☐ No; If No, how many weeks? _____

Illnesses or accidents during pregnancy: _____

_____

Use of alcohol, tobacco, or medications during pregnancy: _____

_____

Any other unusual conditions that may have affected pregnancy and/or birth? _____

_____

Birth weight: _____ Delivery: ☐ Vaginal ☐ Cesarean ☐ Breech

Medical History

Please check if your child has had any of the following (and if so, at what age):

- ☐ Adenoidectomy_____
- ☐ Allergies_____
- ☐ Asthma_____
- ☐ Breathing Difficulties_____
- ☐ Chronic Ear Infections_____
- ☐ Ear tubes_____
- ☐ Encephalitis_____
- ☐ Hearing Loss_____
- ☐ Head Injury_____
- ☐ High Fevers_____
- ☐ Measles_____
- ☐ Meningitis_____
- ☐ Mumps_____
- ☐ Scarlet Fever_____
- ☐ Seizures_____
- ☐ Sinusitis_____
- ☐ Sleeping Difficulties_____
- ☐ Thumb/Finger Sucking_____
- ☐ Tonsillectomy_____
- ☐ Vision Problems_____

Explain any checked items here: _____

_____

If your child has had ear infections, how many? _____

How have the infections been treated? _____

Has your child had, or have, ear tubes? If yes, when did they receive the ear tubes and how long were they in place? _____

Please list all medications your child is taking: _____

_____

List all known allergies: _____

_____

Has your child ever had surgery or any other hospitalization? _____

_____

If your child has vision problems, what was/is the treatment? _____

Does your child have dental problems? _____ If so, what is/was the treatment? _____

Any additional information you would like us to know: _____

_____

Developmental History

In your opinion, how does your child's overall development compare to that of other children his/her age? _____

_____

Give the approximate age at which your child:

Sat unsupported: _____ Crawled: _____ Stood: _____

Walked alone: _____ Was toilet trained: _____ Feed self: _____

Dress Self: _____ Tie Shoes: _____

Grasped crayon/pencil: _____

Language Development

Please give the approximate age your child achieved the following:

Babbled: _____ Spoke First Word: _____

Put Two Words Together: _____ Spoke in sentences: _____

Which sounds, if any, are incorrect? _____

How many words can your child say? _____

If fewer than ten, please list: _____

How long are your child's sentences? _____

Does your child have any difficulty understanding you? (If so, please describe) _____

_____

Does your child have difficulty following directions? (If so, please describe) _____

_____

Are there any speech or hearing problems in the immediate or extended family? (If so, please explain) _____

_____

Does your child….

- ☐ Choke on food or liquids?
- ☐ Currently put toys/objects in his/her mouth?
- ☐ Brush his/her teeth and/or allow brushing?

Please explain any of the above: _____

Your child currently communicates using:

- ☐ Body Language
- ☐ Sounds (vowels, grunting)
- ☐ Words (shoe, doggy, up)
- ☐ 2 to 4 word sentences
- ☐ Dialogue

Is your child left or right handed? _____

Is your child able to use (check for YES)….

☐ Open cup ☐ Straw

☐ Spoon ☐ Blow Bubbles

Does your child have difficulty (check for YES)….

☐ Swallowing ☐ Blowing

☐ Chewing ☐ Drooling

☐ Drinking

What are your child's favorite foods? _____

List any food aversions: _____

Does your child (check for YES)….

☐ Eat Well ☐ Cry appropriately ☐ Smile

☐ Sleep Well ☐ Laugh

Does your child use sign language or other alternative/augmentative communication (e.g. Dynavox, Proloquo)?

_____

Does your child show unusual behavior (explain)? _____

_____

How does your child respond to: Light? Sound? People? Explain:

_____

Does your child play with others? _____ With who? _____

How would you characterize your child's interaction with:

Siblings: _____ Parents: _____

Peers: _____ Other adults: _____

Has your child attended daycare? _____

Number of regular playmates: _____

Favorite activities: _____

Does your child's attention span seem appropriate for his/her age? _____

Is your child active, hyperactive, or lethargic? If yes, please explain: _____

_____

How does your child handle frustration? _____

_____

What motivates your child the most? _____

What discipline works best? _____

Milton Speech Pathology Therapy & Learning Center of GA

Educational Background

Current School: _____ Grade: _____

Teacher: _____

Other professionals working with your child: _____

How does your child's teacher describe his/her performance? _____

_____

Has the teacher expressed concerns? If so, what? _____

_____

Is your child having difficulty with any subjects? _____

What are your child's favorite subjects? _____

If your child has been enrolled in Special Education services, has an Individualized Education Plan (IEP) been developed? (If so, please attach a copy)

_____

_____

Does your child have a 504 plan? _____ (If so, please attach a copy)

Please provide any additional information you believe might help us better understand your child in this process:

_____

_____

_____

What do you hope to have happen as a result of this evaluation or screen?

_____

_____

Consent Form

This form must be completed before services can be initiated. If the client is under the age of 18 years, all legal guardians must sign the form.

Consent for Treatment: I hereby attest that I have voluntarily applied for and entered into treatment, or give my consent for the minor or person under my legal guardianship, at Therapy & Learning Center of GA. I understand that I may terminate these services at any time.

Consent to Communicate with Insurance Company: I give consent to Therapy & Learning Center of GA and its employees/agents to communicate with my insurance company and to release any health information needed in order to authorize visits and collect payment.

Receipt of Policies and Procedures: I hereby attest that I have received a copy of Therapy & Learning Center of GA's Policies and Procedures, including payment policies, and have read, understand, and consent to be bound by its content.

Receipt of Patient's Rights: I hereby attest that I have received a copy of the Patient Rights notice, have read, and understand its content.

Receipt of Privacy Policy and Consent for Disclosure of Health Information: I have been provided a copy of Therapy & Learning Center of GA's Notice of Privacy Policies detailing how my medical record may be used and disclosed under Federal and State law. I understand that as a part of Therapy & Learning Center of GA's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity (i.e., insurance, emergency, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax and e-mail only to appropriate parties. I fully understand and accept the terms of this Consent and acknowledge the receipt of the Privacy Notice. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I understand that by refusing to sign this consent or revoking this consent, Therapy & Learning Center of GA may refuse to treat me. I further understand that Therapy & Learning Center of GA reserves the right to change its privacy policies and will provide me with a copy of any revised notice.

Photocopy Authorization: I permit a photocopy of this consent form as if it were an original executed consent.

Name of Patient (Printed): _____

By signing below, you are attesting to the accuracy of the above statements including all consents and authorizations implied therein. A copy of this agreement is available upon request.

Legal Guardian Signature Date

_____ _____

Credit Card Payment Authorization Form

Sign and complete this form to authorize Therapy & Learning Center of GA to make a debit to your credit card listed below. We require that patients keep a credit card on file for payment. This is because we do not have front office staff to process your card each day.

By signing this form, you give us permission to debit tour account for services rendered.

Please complete the information below.

I, _____, authorize Therapy & Learning Center of GA to charge my credit card account for the amount indicated on my bill on or after the date of my child's service. If I am using insurance, the credit card will be processed after the insurance company provides and EOB outlining the negotiated rate for services. I will be notified of this rate before my credit card is processed. This payment is for Speech and Language Therapy, Occupational Therapy, or Academic Tutoring. Credit cards are processed at the end of the week.

Billing Address: _____ Phone #: _____

City, State, Zip: _____ Email: _____

Account Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder Name: _____

Card/Account #: _____

Expiration Date: _____ CVC: _____

Signature Date

_____ _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount explained to me. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company so long as the transaction corresponds to the terms indicated int his form and for the amount explained to me.

Milton Speech Pathology Therapy & Learning Center of GA

Policies and Procedures

Appointments:

Please arrive at your appointment 5 minutes early. In the event that you arrive late for your appointment, the appointment may be shortened due time constraints. If you must cancel an appointment, please call immediately. We understand that life happens. We have a 24 hour cancellation policy. ***Therefore, please cancel appointments scheduled for the following day before 10 pm the evening prior via email, phone or text. The full service fee will be charged for no shows and last minute cancellations***. In the case of a **child's illness**, cancellations will be accepted **before 8 am**. ***This includes school visits. Please do not count on your child's school to notify MSP.***

Patients are required to attend 75% of speech sessions. *In the event that attendance drops to 50% over 2 months, we reserve the right to forfeit your child's space.* ***After 2 no show appointments (no call, no email, no text)*** *for any reason, we reserve the right to forfeit your child's space.*
This does not apply to social skills groups. Social skills group students will be offered one make up session free of charge after the semester to cover the cost of all missed sessions. One hour social skills group lessons allow for 50 minutes in group and 10 minutes group/parent education.

Fees:

A schedule of fees can be obtained from our website. **You are required to inform us about changes in insurance. In the event that you fail to inform us and the insurance denies the claim, you will be responsible for the full payment.** Enrollment in social skills groups requires a *non-refundable payment* for the first 50% of classes upon enrollment. For example, when you enroll for an 8 class session, the fee for 4 sessions will be due 1 week prior to the start of group. The remainder is due after the 3rd class. We will charge your card after the 3rd class automatically. We will hold 1 make-up class free of charge after the end of the session for all students who have missed classes**. Verification of insurance is not a guarantee of payment. In the event that your insurance does not pay for service, you will be responsible for the fee. It is your responsibility to let us know if your insurance changes.** If you do not let us know and we do not have authorization for treatment from the new company, they may not pay and you will receive a bill.

Schools: There is a $10 travel fee when therapists see patients at school.

Times: As per the consent form, if you elect to a service time that is beyond what is covered in your insurance, you are voluntarily agreeing to pay for the extra time as per your insurance's adjusted rate.

CAMP: Should you need to cancel camp 4 weeks prior, 100% of your payment will be refunded. Should you need to cancel camp 2-3 weeks prior 50% of your payment will be refunded. Should you need to cancel camp less than 1 week prior, 25% of your payment will be refunded.

_____ _____

Print Client's Name Relationship to Client

_____ _____

Signature of Parent or Legal Guardian Date