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

Educational Tutoring Intake Form

Identifying Information:

Student 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 student): _____

_____

Referral Source:

Referred By:_____ 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? _____

Is there a family history of dyslexia, dyscalculia, dysgraphia, or any other learning disabilities?

_____

_____

Is your child left or right handed? _____

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? _____

Has your child received any therapies or educational assessments? If yes, please list.

_____

_____

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?

_____

_____

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 in this 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