

Amanda Sepe, CCC-SLP, LLC
REGISTRATION FORM
(Please Print)

Today's date:			Primary Care Physician:		
PATIENT INFORMATION					
Patient's last name:		First:	Middle:	Birth date: / /	
				Sex: M F	
Street address:			City:		State:
Phone Number – home cell		Parent names:			Zip code
Email address:		Alternate phone number – home cell			

IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: () ()	Cell phone no.: () ()
<p>I authorize treatment of the person named above. The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance and any balance over 90 days will be sent to collections. I also authorize Amanda Sepe, CCC-SLP to release any information required to process my claims.</p>				
_____ <i>Patient/Guardian signature</i>			_____ <i>Date</i>	

MEDICAL AUTHORIZATION FORM

We, the undersigned, and parent(s)/legal guardian(s) of _____ born on _____ hereby authorize the staff of Amanda Sepe, CCC-SLP, LLC, to call for medical treatment for _____ as they in their discretion see fit.

A photocopy of this authorization shall be deemed effective as if it were an original.

Parent Signature _____

Parent cell phone or emergency number _____

Life Threatening Allergies: _____

Other Allergies: _____

Medications child is currently taking: _____

MEDICAL INSURANCE COMPANY: _____

MEDICAL INSURANCE ID or GROUP #: _____

MEDICAL INSURANCE CO. PHONE #: _____

PEDIATRICIAN NAME: _____

PEDIATRICIAN PHONE #: _____

Acknowledgment of Receipt of Privacy Practices

I acknowledge receipt of a copy of the Notice of Privacy Practices for Amanda Sepe, CCC-SLP, LLC.

Patient or Legal Guardian Signature	Print Name	Date

Authorization to Communicate Via Email/Text

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires that all health care records and other individually identifiable (personal) health information used or disclosed to Amanda Sepe, CCC-SLP, LLC in any form—electronically, on paper, or orally—be kept confidential.

I understand that Amanda Sepe, CCC-SLP, LLC’s email/text is not encrypted and cannot be secured from inadvertent disclosure of personal health information to third persons once the information is sent.

____ In spite of the risk of inadvertent disclosure of my personal health information, I authorize Amanda Sepe, CCC-SLP, LLC to send information (i.e.: reports, receipts, cancellation notices, etc...) that may include personal health information **via email or text**, to any email address provided to Amanda Sepe, CCC-SLP, LLC by the legal parent/guardian.

____ In spite of the risk of inadvertent disclosure of my personal health information, I authorize Amanda Sepe, CCC-SLP, LLC to send information **via text** in regard to *scheduling and cancellations*, that may include personal health information to a personal cell phone number provided to Amanda Sepe, CCC-SLP, LLC by the legal parent/guardian.

____ I understand that I am responsible for providing, **in writing**, any request that Amanda Sepe, CCC-SLP, LLC no longer email/text information to any email addresses/phone numbers the parent/guardian provided.

Patient or Legal Guardian Signature	Date

Attendance and Billing Policies

Please initial to the left of each numbered item so that it is assured that you have read and understood each item.

It is recognized that sickness, emergencies and vacations occur. Your child's success depends on his/her attendance.

_____ (1) Your child's weekly appointment is especially reserved for them. **All "no-show" visits and will be charged at your regular visit cost.** Contact me via text, email or phone to cancel an appointment. **All "late cancellations" which are appointments cancelled later than 7:00 am of the day of the appointment will be charged the regular visit fee.**

_____ (2) Any No Show or late cancelled visit can be rescheduled within four weeks of the missed visit. Every attempt will be made to accommodate a make-up session. Due to scheduling constraints, it might not always be possible to make up a session. You will be charged for a missed session.

_____ (3) I reserve the right to terminate services for excessive missed visits. (Excessive missed visits equal 4 or more scheduled sessions that are missed within 6 consecutive weeks.)

_____ (4) I reserve the right to terminate services for excessive late visits. (Excessive late visits equal 4 or more scheduled sessions where the client arrives 10 or more minutes late for the session within 6 consecutive weeks.)

_____ (5) All requests for notes, emails, summaries will be billed at the hourly rate of 100.00 with a one hour minimum. A 100.00 minimum payment per request is due at the time of the request.

The Team Approach

I work as a team with a parent (and/or another coach) and child. During our time together, your child will learn the special strategies needed for anyone struggling in the process of learning to read, spell, and master printed language. Most students attend once or twice a week, with the parent attending at least 1 session/week. As their coach, you will take part in both the hard work and the pleasure and excitement of watching your child make breakthroughs. You will also be able to recognize later if skills slip and if a few review sessions would be helpful. If you think you and your child might not work well as a team, we can discuss other options, however. Consistent practice is essential, so you should count on practicing at home 3 to 4 days a week for about 20 to 45 minutes. We are trying to change how your child processes language and print. The more you practice, the greater and more stable the gains. I will provide all support material and a lesson plan for your homework.

Initial that the team approach is understood _____

Duration of Therapy: Depending on the severity of the problem, frequency of sessions, and amount of work at home, the duration of therapy is typically between 9 months and 2 years, with an average of 16 months. If, after 6 months of therapy, appropriate progress is not being made, possible reasons and alternative options will be discussed. Although most children with reading and/or spelling difficulties benefit from a structured and sequential phonetic approach, every child is unique, and some may need alternative therapies.

By the end of training, most children should be able to read accurately at grade level and recognize and self-correct any errors. She or he should be able to take grade level dictation, using spelling with sounds in order, vowel sound representing each syllable, and circling any words that need checking. Usually, spelling skills lag behind reading skills, but words will be readable, and will use reasonable English patterns.

Some children achieve grade level reading, but still read slowly, perhaps due to delays in Rapid Naming or Word Retrieval. To date, we know how to help all children become accurate and faster than they were, but not how to have them all become as fast as they might like to be. If your child is one who continues to read slowly, you may ask that written homework be reduced, so she or he can practice accurately and continue to improve.

Initial that duration of therapy is understood _____

Signature of parent/legal guardian who is financially responsible for the client Date