Elite Concierge Speech and Language Services LLC

Please complete as much of this evaluation packet as possible prior to your first appointment. If you need help with any sections, you may call (239) 544-2287 or email information@eliteconciergespeech.com and a representative will be happy to assist you within 24 hours. Thank you in advance for your responses which will be a helpful tool in developing your child's personalized therapy plan.

Speech/Language Intake Form

Name:	**DOB:**	**Age:**	**Sex:** ☐ M ☐ F ☐ Other
School:		**Grade:**	
Legal Guardian 1:		☐ Mom ☐ Dad ☐ Other _____	
Address:		**Phone:**	
Legal Guardian 2:		☐ Mom ☐ Dad ☐ Other _____	
Address *(If Different)*:		**Phone:**	

Birth History:

Were there any problems during pregnancy and/or birth? Yes ☐ No ☐ *(If yes, briefly describe)*

_____

Home Environment:

Who lives at home with the child? (*Siblings (and ages), mother, father, step-parents, grandparents, etc)*

_____

How often is English spoken at home? ☐ Always ☐ Most of the Time ☐ Sometimes ☐ Never

If another language is spoken, what language(s) is/are used in the home? _____

Any special circumstances?

☐ Parents divorced ☐ Joint physical custody ☐ Child adopted ☐ Other _____

Any cultural or religious considerations for therapy? *(holiday celebrations, prohibitions, etc)*

_____

Health History:

Please Mark Appropriate Box(es) If Your Child Has Had Any of The Following:

☐ Frequent Ear Infections ☐ Occupational Therapy ☐ Developmental Delay ☐ Early Intervention

☐ Hearing Problems ☐ Physical Therapy ☐ Premature Birth ☐ Tubes In Ears

☐ Speech Therapy ☐ Head Injury ☐ Hospitalization ☐ Behavior Therapy

☐ Allergies *(list below)* ☐ Prescription Medication *(list below)* ☐ Special Diet *(list below)*

Please Provide Further Explanations for Items Checked Above:

_____

_____

Is Your Child Diagnosed with Any Developmental or Sensory Disorders?

☐ ADHD ☐ Anxiety ☐ Autism ☐ Articulation Disorder
☐ Blind/Visually Impaired ☐ Cerebral Palsy ☐ Deaf/Hard of Hearing ☐ Degenerative Condition
☐ Dyslexia ☐ Down's Syndrome ☐ Fragile X Syndrome ☐ Intellectual Disability
☐ Language Disorder ☐ Learning Disorder ☐ Opposition Defiance Disorder ☐ Sensory Processing Disorder
☐ Social Communication Disorder ☐ Stuttering ☐ Other *(list)* _____

Please Provide Further Explanations for Items Checked Above:

_____

Do You Suspect Your Child Has Any Undiagnosed Disorders? ☐ Yes ☐ No

If yes, explain: _____

Developmental History:

Please include approximate age of occurrence

First word _____ Spoke sentences clearly _____ Typical Motor Development? ☐ Yes ☐ No

Education:

How Is Your Child Currently Educated?: ☐ Caregiver-led at home ☐ Distance Learning ☐ Pre-school/School

Has Your Child Ever Been Held Back a Grade? ☐ Yes ☐ No

Which Subjects in School is Your Child on Grade Level for? ☐ Reading ☐ Math ☐ Science ☐ Social Studies

Does Your Child Receive Special Education Services? ☐ Yes ☐ No

Does Your Child Have an IEP, SSP, or IFSP? ☐ Yes ☐ No

If yes, what is it targeting? _____

Communication & Social Interaction

Does Your Child Play Well with Other Children? ☐ Yes ☐ No

Which of the Following Apply to Your Child?

☐ Cooperative
☐ Anxious
☐ Hyperactive
☐ Frequent tantrums
☐ Frequent self-stimulation (spinning, hand flapping, etc)
☐ Plays independently with others
☐ Easily frustrated/impulsive
☐ Inappropriate behavior
☐ Minimal eye contact
☐ Poor understanding of danger

Can Your Child Clearly and Appropriately Communicate the Following?

☐ Statements ☐ Questions ☐ Answers ☐ Wants ☐ Needs (ex: help) ☐ Feelings ☐ Denial/Protests ☐ Discomfort

About How Much of What Your Child Says Can You Understand? ☐ Almost All ☐ Most ☐ Half ☐ Quarter or Less

About How Much Could a Stranger Understand? ☐ Almost All ☐ Most ☐ Half ☐ Quarter or Less

Your Thoughts:

Why Do You Think Your Child Has a Communication Delay/Disorder?

_____
_____

What Have You Already Tried to Remedy the Communication Delay/Disorder? Has it Helped?

_____
_____

What Is the Main Goal You Wish to Accomplish with Speech/Language Therapy?

_____
_____

What Methods Do You Consent to Be Utilized for Communication Regarding Your Child?

☐ Text ☐ Email ☐ Voicemail

PLEASE PRINT YOUR NAME: _____ **Date:** _____

SIGNATURE: _____

PLEASE INDICATE RELATIONSHIP TO CHILD: ☐ Parent ☐ Other Legal Guardian

ECSLS Child Preference Assessment

Favorite Food(s): _____

Favorite Drink(s): _____

Favorite Color(s): _____

Favorite People: _____

Favorite Comfort Object (i.e. blanket, stuffed animal): _____

Favorite Toys/Activities:

_____

_____

Favorite Sport: _____

Favorite Animal: _____

Favorite Hobbies/Entertainment:

_____

_____

Favorite Book(s): _____

Favorite TV Show(s): _____

Favorite Movie(s): _____

Favorite Video Game(s): _____

Favorite Character(s): _____

Favorite Restaurant(s): _____

Favorite Places in the Community:

_____

_____

Favorite Reinforcers (i.e. stickers, high fives, praise, food):

_____

_____

Please list any other preferred or motivating activities your child enjoys:

_____

_____

Thank you for your valuable input.

MEDICAL RECORDS RELEASE FORM AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

1. I, _____, of _____,
   (Parent/Guardian) (Client Name)

   date of birth: _____ hereby authorize Elite Concierge Speech and Language Services LLC to use, disclose and/or discuss the following protected health information listed below from my medical records. I understand the information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting confidentiality.

2. Persons or entities with whom Elite Concierge Speech and Language Services LLC may disclose/discuss your Protected Health Information: (Releasees- i.e. Doctors, Dentists, Therapists, Schools/Teachers, etc.)

Name/Title	Address	Phone/Email

3. Elite Concierge Speech and Language Services LLC is authorized to disclose/discuss the following information, including but not limited to: medical records; treatment records (progress notes, daily session notes); speech, language, academic, and/or swallowing test results; and evaluations/therapy progress as it relates to therapy/treatment and evaluations at Elite Concierge Speech and Language Services LLC.

4. This information is being used or shared for medical, insurance, legal, and/or educational purposes.

5. I understand that I may revoke this authorization at any time by requesting such of Elite Concierge Speech and Language Services LLC in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

_____ _____
Parent/Guarantor Signature Date

_____ _____
Parent/Guarantor Name (Printed) Client Name (Printed)

THERAPY POLICIES

Elite Concierge Speech and Language Services LLC provides a model of care that allows our clients to maximize their potential for progress. Our therapy policies allow us to serve each client by reserving weekly appointments and accommodating the need or request for additional therapy.

Cancelled Appointments

24 hours' notice is required for any cancelled appointment. Failure to provide 24 hours' notice will result in a $50.00 cancellation fee charged to your account. Exceptions will be made for occasional and unavoidable circumstances, such as sudden illnesses, that do not allow for advance notice.

No-Show

Our therapists spend time planning and preparing for each therapy session. Missed appointments without prior notice (either directly to the treating therapist or administrative staff) will be charged at the private pay rate.

I acknowledge receipt of and agree to the therapy policies of Elite Concierge Speech and Language Services LLC. Signature: _____

HIPAA PRIVACY NOTICE ACKNOWLEDGMENT

1. Elite Concierge Speech and Language Services LLC is required by law to keep your health information safe. This information may include notes from your doctor, teacher, or other health care providers; your medical history; your test results; treatment notes; and insurance information.
2. Elite Concierge Speech and Language Services LLC is required by law to give you a copy of our privacy notice. This notice explains how your health information is used and/or shared. It also explains you how you can obtain your information and comment on it.

I acknowledge receipt of Elite Concierge Speech and Language LLC's Privacy Notice. Signature: _____

PAYMENT AGREEMENT

Elite Concierge Speech and Language Services LLC is a private-pay agency, however a detailed, monthly therapy statement will be provided to the client/guarantor for submission to an insurance company listing Elite Concierge Speech and Language Services LLC as an out-of-network provider. Payment is due at time of services rendered. Any costs incurred by Elite Concierge Speech and Language Services LLC for any returned checks or insufficient funds is the client/guarantor's responsibility.

I acknowledge receipt of and agree to the Payment Agreement outlined above. Signature: _____

CONSENT TO TREAT VIA TELETHERAPY

1. I have the right to withhold or withdraw my consent to teletherapy, in writing, at any time without affecting my right to future care or treatment.

2. The laws that protect the confidentiality of my medical information (HIPAA) also apply to teletherapy, as do all other applicable Company policies, e.g. Payment Agreement.

3. I understand that through no fault of Elite Concierge Speech and Language Services LLC there are certain unavoidable risks associated with engaging in teletherapy, including, but not limited to: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

4. I understand that teletherapy based services and care may not be as complete as face-to-face services. Should Elite Concierge Speech and Language Services LLC, in consultation with the client's treating therapist, make a clinical judgment that teletherapy services are not effective, the Company reserves the right to discontinue teletherapy in accordance with "best practice" standards and refer the client to in person therapy services.

5. I understand that I/my child may benefit from teletherapy, but that results cannot be guaranteed or assured.

6. If I have concerns regarding teletherapy, I will direct my concerns, in writing, to information@eliteconciergespeech.com .

7. I understand that I am responsible for:

(1) Providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions

(2) Ensuring information security on my computer

(3) Arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my/my child's teletherapy session.

I acknowledge receipt of and agree to the Consent to Treat Via Teletherapy outlined above. Signature: _____

In consideration for the professional services rendered to me or my child, by Elite Concierge Speech and Language Services LLC, I acknowledge receipt of and agree with Elite Concierge Speech and Language Services LLC's Office Policies and Agreements outlined above.

_____ _____

Parent/Guarantor Signature Date

_____ _____

Parent/Guarantor Name (Printed) Client Name (Printed)

Thank you so much for completing our office documents. We are looking forward to working with you and your family soon.

Communication is essential for a happy life. ©