Monroe Speech & Language Center

Child's Name: _____ **Date Of Birth:** _____
Parent Name(s): _____ **Phone Number:** _____
Address: _____ **Cell Number:** _____
_____ **Email:** _____
Siblings (number & ages): _____
Primary Language: _____ **Secondary Language:**_____
Primary Care Physician: _____ **Clinic/Phone:** _____

Describe your current concerns regarding your child's speech and language:

Does your child have a medical diagnosis (e.g., Autism Spectrum Disorder, Cleft Palate, Cerebral Palsy, Down Syndrome, ADHD, Sensory Integration Disorder)? When was the diagnosis made, and by whom?

Has your child been evaluated by any other specialists? If yes, please describe:

Is there any family history of speech or language problems? If yes, please describe:

Has your child ever regressed in his/her language skills (e.g., used language but then "lost" some of the language)? When/Describe:

PRENATAL AND BIRTH HISTORY

Length of Pregnancy: _____ Length of Labor: _____
General Condition: _____ Birth Weight: _____
Type of Delivery (please circle): head first feet first breech caesarian

Were there any unusual conditions that may have affected the pregnancy or birth? Describe:

MEDICAL HISTORY

Has your child had any ear infections, frequent colds, or other significant medical history? Please describe:

Does your child have asthma or any allergies (including allergy to latex or allergies to any foods)? Describe in detail:

Has your child ever had any seizures? Please describe:

Has your child ever had pneumonia or very high fever? Please describe:

Is your child taking any medications? If yes, identify:

Has your child ever had a hearing test completed? If yes, when and describe results:

PE Tubes? Yes No Tonsillectomy? Yes No Adenoidectomy? Yes No

Has your child had any major accidents, hospitalizations, or surgeries? If yes, please describe:

DEVELOPMENTAL HISTORY

Provide, to the best of your knowledge, approximate age (including month) at which your child began to do the following activities:

Crawl _____ Sit _____ Stand _____Walk _____
Feed Self _____ Dress Self _____ Use Toilet _____

Say First Word _____ Combine Words _____
Name Simple Objects _____ Use Simple Questions _____

Does your child have difficulty walking, running, or participating in other activities which require small or gross muscle coordination?

Are there or have there ever been any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing, limited food repertoire, etc.)? If yes, please describe:

Will you allow your child to have food/snack items as part of their therapy? Any restrictions?

EDUCATIONAL HISTORY

School: _____ Grade: _____
How is your child doing academically (or pre-academically)?

Does your child receive special services? If yes, describe:

How does your child interact with others (e.g., shy, aggressive, uncooperative, etc)?

If enrolled for special education services, has an Individualized Education Plan (IEP) or 504 Plan been developed? If yes, describe the most important goals:

Please provide any additional information that might be helpful for your child's evaluation and/or treatment:

Person Completing Form: _____ *Relationship to Child*: _____

Signed: _____ *Date*: _____

Monroe Speech & Language Center

Office Policies

Welcome to Monroe Speech & Language Center! We look forward to working with your child. To help all of our clients make optimal progress, and to ensure fairness to all clients and to our clinicians, we very strictly adhere to the following Office Policies. It is each family's responsibility to be familiar with our policies, to kindly follow the rules we have set for our clinic and waiting room, and to commit to faithful attendance in order to keep your child's therapy slot.

Waiting Room Policies:

- *Leaving*: During your child's session, you will be expected to remain on the premises unless arranged with your clinician. You must return before the session end time so that subsequent clients can be seen on schedule.

- *Disruptive Behavior*: We reserve the right to discontinue services for any client if we feel his/her behavior is disruptive or unsafe towards others in our waiting room or with his/her therapist. This includes behavior of siblings that are in any part of our clinic as well.

- *Food*: *Snacks containing peanuts are not allowed in our waiting room* due to allergy issues for some of our clients. For all other snacks, we ask parents to be considerate in cleaning up after their children.

- *Noise*: Our waiting area is small and very close to some of our treatment rooms, and noise travels quite a bit in our clinic. In fairness to our clients and our therapists, we request that parents be conscientious about the noise levels in our wait room. Loud children are disruptive to our sessions and interfere with our clients' ability to concentrate.

Attendance Policies:

- *Attendance Expectation*: In order to help your child make optimal progress, consistency of attendance is very important. We require a 75% attendance rate every month in order for your child to remain on schedule. If your child falls below 75% attendance, s/he will be placed back onto our wait list.

- *Cancellations*: 24 hours notice is required for all cancellations. If less than 24 hours notice is given, *you will be charged a fee of $50*. If an alternate time is available within one week of

your original appointment, you will be offered the opportunity to reschedule and the fee will be waived (a reschedule opportunity cannot be guaranteed).

- *Emergencies and Illness:* In the event that your child becomes suddenly ill prior to a session, please alert your therapist as soon as possible (and at least *one hour prior* to your scheduled time) to cancel. If you do not provide at least one hour notice when your child is ill, you will be subject to a late cancellation fee of $50. All emergency situations will be considered on a case by case basis.

  Please use common sense in cancelling. If your child is contagious (or may be) or clearly isn't feeling well, you are asked to keep him/her home out of consideration for your child, our therapists, and other families.

- *No Shows: You will be charged $50 for any no show appointments* (please note that this cannot be billed to insurance, and will be your responsibility to pay before resuming therapy and within 2 weeks of the no-show appointment).

- *Vacations or Extended Time Off:* During summer months, our cancellation policy remains in effect. If your schedule dictates that your child will not be able to attend 75% of appointments, your time slot will be made available to another client and your child will be placed back onto our waiting list.

- *Weather Policy:* Please follow the Monroe School District schedule related to inclement weather. If Monroe School District is closed, then MSLC will be closed. If the Monroe SD is operating on a delayed schedule, please contact your therapist to determine if there is a schedule change for your child's appointment.

The signature below confirms that I give consent for my child to receive ongoing speech-language evaluation and services as provided by speech-language pathologists at Monroe Speech & Language Center. My signature below also confirms that I have read and understand the above Office Policies.

Client's Name Date

Parent's Signature

NOTICE OF PRIVACY PRACTICES

The terms of this notice of privacy practices applies to Monroe Speech & Language Center (Kristi L. Tekel, LLC), Jodie Hastings, LLC, and Brenda Ray, LLC. We are required by law to maintain the privacy of our patients' health information and to provide patients with notice of our legal duties and privacy practices with respect to your personal health information.

Use and Disclosures of your Personal Health Information

Except as outlined below we will not use or disclose your personal health information for any purpose unless you have signed a form authorizing the use or disclosure. You have the right to revoke the consent or authorization in writing unless we have taken any action in reliance on the consent or authorization.

We will make uses and disclosures of your personal health information as necessary for your treatment. We may also release your personal health information to another health care facility or professional who is or will be providing treatment to you. We will make uses and disclosures of your personal health information as necessary for payment purposes. For example, we may use your health information for purposes of preparing a bill to send to the entity responsible for payment; this may be you or an insurance company. We will use and disclose your personal health information for operations, which include clinician improvements, or as required by law.

With your approval we may disclose your personal health information to your family and friends involved in your care. This will require your written release and consent and will only be given to the designated individuals in your release.

Business Associates

Certain aspects of our services may be performed by contracts with outside persons such as accreditations, auditing or legal services. At times it may be necessary for us to provide certain information from your personal health care information to allow for this service. In all cases we require these entities to safeguard the privacy of all information under the requirements of HIPPA.

Access to Personal Health Care Information

You have the right to copy and inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your representative. We may charge you for copying, mailing, and compiling the information.

Accounting and Disclosure of Your Personal Health Care Information

You have the right to receive an accounting of certain disclosures made by us of your personal health care information. All requests must be in writing and sent to Monroe Speech & Language Center, attention HIPPA Compliance Officer.

Disclosure of Health Information Restrictions

You have the right to request restrictions on certain uses and disclosures of your health care information. While we are not required to consent to your request as it affects health care operations, billings or as required by law, we will attempt to accommodate such requests. We retain the right to terminate an agreed to restriction if it becomes necessary to meet business operations such as health care delivery, billings, or as required by law.

If you believe your privacy rights have been violated you may file a complaint in writing with the HIPPA Compliance Officer at Monroe Speech & Language Center/Kristi Tekel, LLC, Jodie Hastings, LLC, or Brenda Ray, LLC.

Acknowledgement of Receipt of Notice

You will be asked to sign an acknowledgement form that you have received this Notice of Privacy Practices. Please sign and date the form and the signature page will be kept on file.

Effective Date of this Notice August 1, 2020.

I have received and read the above notice regarding my rights to privacy for my Protected Health Information.

_____ _____

Signature of Client or Representative Date