Hamaguchi & Associates
Pediatric Speech-Language Pathologists, Inc.
20111 Stevens Creek Blvd., Ste.145
Cupertino, CA 95014
(408) 366-1098 • fax (408) 366-1011
www.hamaguchiandassociates.com

For Office Use Only:

Date Recvd: _____ Parent called: _____ by: _____ Reg Fee: ❑yes ❑no ACH: ❑yes ❑no Conf. Sent: ❑ Conf. Recvd: ❑

2021-2022 Academic Year Service Request Form for New Clients

Child's Name_____ DOB_____ Age_____
Address_____
City/Zip_____

Mother's/Father's/Guardian's/Partner's
Name_____
Email: _____ Cell: _____

Father's/Mother's/Guardian's/Partner's
Name_____
Email: _____ Cell: _____

What is the best phone # to reach you? _____
May we leave a message for you on this number? ❑Yes ❑No

What we need from you prior to beginning therapy:

1. This Registration Form, along with the equivalent of 2 sessions' *fees if a credit card or voided check is not provided.* (If attending group and individual, the equivalent of one group and one individual session). We require a credit card on file for payments or you may sign up for ACH (automatic bank withdrawal).
2. A Patient History Form
3. Copies of previous speech-language pathology reports, as well as any other pertinent reports, such as those from an occupational therapist, IEP, or psychologist. We will need to have some kind of speech evaluation or report that is no older than 11 months old, in order to begin services. Children with minor articulation difficulties can usually suffice with a screening by our staff. If you have no report and your child has anything other than a very mild, simple deficit, we will need to perform an evaluation first. Insurance companies do require an initial assessment and treatment plan (goals*). IEPs are considered "educational" and therefore, if our therapy is based on an IEP, your insurance company will decline coverage, indicating it is duplication of services and educational in nature rather than medical.*

What services are you requesting to be scheduled?

- ❑ **Assessment**
  - ❑ **Individual or Group Services**
  - ❑ **I'm not sure what my child needs.** *(Please send us all previous reports and we will give you input on this)*

Please fill out this form and return it to our office.

1. Include a short note (1-2 pages, max, please) on a separate sheet of paper, "What We Want You to Know About Our Child" including information about your child's personality, your concerns, observations and reasons for seeking an assessment and/or therapy at our office.
2. *Please include a photograph of your child that we can keep in our records.*
3. Fax it or email it (frontoffice.hamaguchi@gmail.com), or mail this form, plus your letter, to our office:

Hamaguchi & Associates
20111 Stevens Creek Blvd. #145, Cupertino, CA 95014
Phone (408) 366-1098 ext 3# / Fax: (408) 366-1011

ASSESSMENTS

My child needs to be assessed: ____ yes _____no _____ I'm not sure

I would like the following type of assessment:

- ❑ Articulation Assessment - **$250** (If no report is required - $196; *pronunciation issues only)*
- ❑ Birth-Age 2: speech-language assessment for children - **$600**
- ❑ Age 3 to 4 years 11 months: speech-language assessment: **$800**
- ❑ Age 5 years to 6 years 11 months: **$1000**
- ❑ Ages 7 and up: **$1299. **with auditory processing tests $1500**
- ❑ Supplementary Testing: for children who have previous speech-language, neuropsychological or similar reports/assessments within the past 9 months and whose parents would like additional information, such as aspects of auditory processing or a more-in depth expressive language component to what was already done. Fees are prorated by time spent but do not include a written report. Reports are billed separately with our "Additional Services Form."
- ❑ An initial mini-assessment for a child wishing to join a group (group only therapy) **$400**

THERAPY

1. **What kind of therapy would you like for your child?**

☐ **Teletherapy only** ☐ **In-person only** ☐ **Hybrid** ☐ **I'm flexible!**

How many sessions per week do you wish to schedule? _____

2. How long for each session?

- ❑ 30-minute individual sessions typically available before 2pm only ($98) *must schedule a minimum of 2 per week*
- ❑ 45-minute individual sessions ($147)
- ❑ One hour ($196)

3. Do you have a preference for which speech pathologist works with your child?

_____

4. *Days* your child is available (please check all that apply):

- ❑ Monday
- ❑ Tuesday
- ❑ Wednesday
- ❑ Thursday
- ❑ Friday
- ❑ Saturday am teletherapy

5. *Times* your child is available to START each session (please check all that apply):

- ❑ 8:00-8:15 (Amber only)
- ❑ 8:15am to 10am
- ❑ 10am to 11:15am
- ❑ 1pm to 2pm
- ❑ 2pm to 3pm
- ❑ 3pm to 4:45pm

GROUP THERAPY (3-6 children) or DYAD (Group of 2 children)

Are you interested in a group for your child? ____ **yes** _____ **no** ____ **maybe**

Groups are used to teach children how to understand and use language (verbal and body language) in an age-appropriate manner in a playful and fun environment with their peers. What days/times is your child available for a group?

_____

HANEN PROGRAM FOR PARENTS (It Takes Two to Talk)
We provide Hanen parent coaching via Zoom classes for parents of young children who are speech-delayed. This is an 8 week program for $800. It provides concrete strategies to help you help your children learn to talk, or talk more. This can be taken instead of therapy or alongside therapy. Days/times vary, often in the evenings. If you would like more information about this program, please check here: _____

6. I have read, understand, and agree to all pages of the 2021-2022 Academic Year Office Policies. I am the financially-responsible parent who will guarantee payment for the program to be scheduled. (*If divorced and sharing joint custody under court order, both parents must sign)

_____
(Please print your name here)

_____ _____
* Signature of parent who is financially committing to pay for this program Date

_____ _____
Signature of Parent with Joint Legal Custody Date

Office Policies: Academic Year Program 2021-2022

I am registering my child for therapy at Hamaguchi & Associates. I understand that:

_____1) **Fees:** After almost three years without raising rates, we unfortunately do need to raise them to keep up with the costs of our rent, insurance, and staff salaries. The new fees, effective August 23, 2021 are:
Individual Session Fees are: $103 per half hour; $155 per 45 minutes, $204 per hour
Groups Sessions are scheduled when appropriate. Fees for each child are: $145 per 60 minute session for a group of three or more children, $185 per 60 minute session for a group of 2 children, $217 for a 90 minute group of 3 or more children. *You will be billed for whichever fee is appropriate, depending upon the number of children attending the group that day.*

_____**2) Attendance/Cancellation Policy:** My child is expected to attend therapy on the day/time scheduled. If I am late, I will still be billed the usual fee and the session will conclude at the scheduled time. If I do not call ahead and cancel or **give less than 3 hours' notice**, I will be charged the full fee for the session. (Fully-paid sessions are not counted towards absences.)

_____3) **Holiday closures:** The following dates are holidays and times the office is closed. If I celebrate a religious holiday that is not listed here, I will let the office know at the time of registration and my child will also be exempted those days as well (up to two dates, maximum, please). Please note that only the actual religious holidays are exempted if they fall on your child's therapy appointment day, *not vacation times that surround those holidays.*

- **September 6th** (Monday) **Labor Day**

- **November 25th & 26th** (Thurs & Fri) **Thanksgiving & day after**
- **December 24th** **Christmas Eve**
- **December 31st office closes at 12pm** (Friday) **New Year's Eve**
- **February 21st** (Monday) **President's Day**
- **April 15th** (Friday) **Good Friday**
- **May 30th** (Monday) **Memorial Day**

_____4) **Absences and holding your child's slot:** My child is allowed to miss up to 4 sessions per academic year if he/she comes once a week, 8 sessions if he/she comes twice a week, 12 sessions if he/she comes 3 times a week, etc. Group sessions are prorated in a similar manner, separately. The holidays listed above are not counted. ***After that, I will be charged ½ the regular session fee of any session I cancel, for any reason to hold my child's slot***. I understand that insurance companies do not reimburse for cancellation fees. Due to scheduling constraints, no make-ups are allowed.

_____5) **Cancelling the Program:** If I choose to withdraw my child for any reason, I will fill out a "Notice to Cancel/Change Therapy Schedule" form giving 14 days' notice. (This is counted from the day it is received, not mailed.) All sessions scheduled during the 14-day period must be paid for, regardless as to whether or not my child attends them.

_____**6) Change of schedule**: Any change in schedule, including reducing the number of sessions per week, or changing the day or time, requires a 14-day notice via a "Notice to Change Therapy Schedule" form, which is counted from the day Hamaguchi & Associates receives written notice. Any sessions scheduled during the 14-day period must be paid for, regardless as to whether or not my child attends them.

_____**7) Insurance:** Insurance companies require certain reports and regular assessments. If I plan to seek reimbursement, I must let Hamaguchi & Associates know at the start of therapy and assume any added cost, as well as providing the front office with the appropriate documentation. (Insurance card and physician's prescription). If my insurance company requires that a written report, I will give Hamaguchi & Associates at least 3 weeks' notice and fill out the "Additional Services Request" form and pay the associated fee for this service.

_____78 **Receipts:** We provide weekly or monthly statements at your request. We are happy to provide copies of these for the current year. Unfortunately, we cannot provide customized statements. After our accountants have closed out our books in early March, we cannot provide a custom or year-long summary of charges. We can only reprint or resend the original statements at any time, and cannot provide courtesy custom printouts for specific blocks of time due to the time it requires.

_____9) **Parental Authority to Commit to Services:** By signing this contract, I am signifying that I have the legal authority to make decisions about this child's care. If I have a custodial agreement due to a divorce, I will have my child's other parent sign as well, even if he/she is not financially responsible for paying for the sessions.

_____**10) Refusal to honor contract:**
Please understand that our policies are not negotiable and must be uniformly enforced. If you are not prepared to honor these policies, please do not register for services as this is a legal contract. Clients who refuse to honor the office policies are subject to being asked to find another provider for services and having their child's program discontinued.

_____**11. Supervision of Children**:
Please make sure you closely supervise your children in the courtyard of our office building. As it is a business office building, please do not let your children run around the courtyard, scream or disrupt the other businesses. Children must remain on the sidewalk at all times.

_____**12. Recording of Teletherapy sessions:** We reserve the right to record all teletherapy sessions. These are used for the Director/Executive Director to consult with the treating SLP on your child's case, and also may be used for training purposes with other in-house therapy staff. In that event, we will not disclose identifying information

other than the child's first name. *At no time, will teletherapy sessions be shared or shown publicly or online.*

_____

(Please print the name of the parent who is financially committing to pay for this program here)

_____

* Signature of parent who is financially committing to pay for this program Date

*If divorced and sharing joint custody under court order, both parents must sign below to give us permission to provide services regardless of who is paying for the services.

_____

Please print the name of the second parent Date

_____

Signature of second parent who grants permission for services Date

Payment Arrangements

Payments will charged on your credit card or through ACH (direct bank withdrawal) the following Monday for the previous week's charges.

- ❑ **Automatic Bank Withdrawals:** I am attaching a voided check for ACH withdrawal and will fill out the information required in the box below. (If you have been doing ACH withdrawal all along, we don't need a new check. Only attach a voided check if you are switching over to ACH)
- ❑ **Automatic Credit Card:** We will charge your credit card for all fees.
- ❑ *I will pay by check in person when I come for my child's appointments. This is only available Monday-Thursdays between 8:30-4:45pm. **A credit card on file is still required in the event a payment is missed.**

Sign Me Up for ACH! (Attach a Voided Check)

(If you currently participate in this plan, you do not need to fill this out again)

Automatic Payment Withdrawals Directly from Your Bank

____ (initial) I authorize Hamaguchi & Associates to withdraw all fees due to maintain my child's speech therapy program and account in good standing including registration fees, therapy/cancellation fees, report-writing fees, etc., per the office policies. Fees are withdrawn the date incurred or shortly thereafter. A statement/receipt will be sent or hand-delivered the next month with the prior month's fees detailed. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. Law.

Bank Name (Depository)_____
City where bank is located: _____ State_____
Zip code where bank is located:_____
Pick one: ___checking ___ savings ____money market fund

Routing number _____
Account number _____

Billing Address ___same as home No, it's different:_____
Name on Account: _____
Signature:_____
Child's Name:_____
Today's Date:_____

You may revoke this authorization at any time by notifying Hamaguchi & Associates in writing that you are revoking this authorization, providing adequate notice to complete in-progress transactions.

Don't forget to include a voided check.

Please attach check here.

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Credit Card Recurring Payment Authorization Form

(Complete only if changed from what we already have on record)

Here's How Recurring Payments Work:
You authorize regularly scheduled charges to your Visa, MasterCard, or American Express. Your card will be charged the corresponding amount for sessions which your child(ren) attend each week. Payments are processed on the Monday following each session. You agree that no prior-notification of each charge will be provided unless the date or amount changes. Only one authorization form is needed per family.

Please complete the information below:

I _____ authorize Hamaguchi and Associates to charge my credit card (full name)

indicated below on a weekly basis for payment of sessions for

_____ or for any other fees I direct to be charged to my card.
(name(s) of children)

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ American Express

Cardholder Name _____

Account Number _____

Expiration Date _____ **CVV2/CVC Code (3 Digits on Back of Card):** _____

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. 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 unless there is an error.

Office Policies: Academic Year Program 2021-2022

1. **Payment:** Credit card on file or payment by check at the window. All Saturday clients must pay by credit card as there is no office staff available on Saturday and these sessions are teletherapy. Failure to pay in a given week by check will mean that we process fees due on the credit card on file.

2. **Sessions:**
   When you have a scheduled therapy time, you are contracting for a specified amount of our professional time (usually 30, 45 or 60 minutes). Direct therapy is usually concluded about 5-7 minutes before the session is over in order to review the exercises with you and answer any questions you may have. All conversations need to take place during the child's scheduled therapy time. With rare exception, we prefer that email communication is not used to query or discuss issues with our therapy staff members as our fees are time-based.

3. **Arriving Late to your Session:**
   If you are late to arrive at your appointment, your child's session will still need to conclude at the usual time in order to keep our schedule on track and you will be billed for the entire scheduled session.

4. **Late Pick-up of Children After the Session:** Children who are not toilet trained or are unable to independently use the bathroom cannot be dropped off for therapy. An adult must stay on the premises at all times. If a child is able to be dropped off, the parent must be back at our office 5 minutes or more before the session is scheduled to be concluded. *Hamaguchi & Associates cannot provide babysitting services.* Our office staff is busy answering phones and taking payments and cannot supervise children. They are contracted to leave by 5pm. Failure to return in time for pick-up will result in a contact from our Director. A repeated issue with on-time pick-up will necessitate a parent be required to wait on-site.

5. **Communication with Other Professionals**:
   We will be happy to speak to whomever you would like via phone regarding your child's program, (physician, OT/PT, etc.) at no additional charge if the conversation is 10 minutes or less. Consultation fees are required for conversations longer than 10 minutes. An Exchange of Information form will need to be filled out, available at the front desk or by emailing Candace (frontoffice.hamaguchi@gmail.com), in order to do so. Max 4 contacts per year without additional charges.

6. **Treatment Plans and Reports**:
   Please fill out the "Additional Services" request form to request a report for your insurance or school or simply for your records. There are fees associated with these additional services.

7. **IEPs and Legal Proceedings:**
   We will generally decline to participate in IEP meetings, legal proceedings, or marital/custodial squabbles, particularly as it relates to scheduling and payments. You must work out these issues before contacting our office. Our office will not act as a mediator between custodial parents.

8. **Interacting with Our Office Staff**:
   Should there be repeated no-shows or unusual difficulties with rescheduling and/or conflict with our office staff (e.g. becoming hostile when asked to pay for a no-show, rescheduled fee, or late cancellation, demands to avoid fees per contract) the front office has the right to refuse to reschedule any further sessions, and the Director will be asked to intervene and handle all further scheduling/billing situations.

Questions and Answers About the Academic Year Office Policies

How can I reschedule sessions?
We will try to accommodate any requests for rescheduling individual sessions, but cannot guarantee our ability to do so, given the very tight schedule our speech pathologists have.

Will my insurance company reimburse me for session fees that are due to a program cancellation or no-show/late notice?
Unfortunately, insurance companies only reimburse therapy sessions that actually take place. Likewise, your Health Savings Account will most likely not allow you to use those funds for cancelled sessions. Therefore, it is important to wait until your plans are firmed up for the summer before scheduling therapy with us.