Thank you for choosing WordsWorth Speech Language Pathology for your adult Literacy and Learning evaluation. Enclosed is our **Adult intake form with case history**. This form must be filled out and returned to us a week before your evaluation. We ask that you complete this form with all pertinent information to ensure that you receive the most comprehensive evaluation possible. Please note the following:

* If you have participated in **any other evaluations** (e.g., speech-language, psychological, neuropsychological, educational testing) **at other facilities, please include copies of these reports with the completed intake form** so that we can tailor our assessment and better meet your needs.
* If you currently have a **workplace accommodations** or a **504 plan in place, please include a copy with the intake form**.
* Please review our **Attendance and Payment for Services Agreement** and bring this to your first appointment.
* A **Patient Information Release** is enclosed should you wish for us to share findings with educators or physicians.
* Lastly, we have provided you with **Federal HIPAA Act Information and Signature Form** for acknowledgement of these policies.
* Please be advised that you must send a deposit of $100 within seven days of booking your appointment to hold the time slot. This fee is to review your records and communicate prior to the evaluation. If you must cancel your appointment, you must do so 72 hours (three days) before the appointment to receive your deposit back (minus the time already taken to review your files, records, etc.) If you fail to cancel your appointment within that time frame or if you miss the appointment, you will forfeit your deposit.

**Please complete all four forms and submit these to WordsWorth via mail or email at least one week prior to your first appointment.**

I look forward to working with you.

Lesley Pech MA, CCC-SLP, CBIS

Speech Language Pathologist

|  |
| --- |
| OFFICE USE ONLY |
| DATE RECEIVED |  |
| REVIEWED BY |  |

**Adult Speech and Language Evaluation Intake Questionnaire**

**and Case History Form**

|  |  |
| --- | --- |
| Name (use initials only, if not hand delivered): | Date of birth: |
| Sex: | Age: |
| Home address:  |
| Referred by: | Contact information: Name: Email:Phone:May we leave private information on this phone number/email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Emergency contactName: Email:Phone:May we leave private information on this phone number/email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Questionnaire filled out by:Relationship to client: |
| Primary Physician’s name:Name of practice:Address: Phone number: |

**Describe specific concerns regarding your language and or literacy challenges and how they impact your work, education, and home life:**

|  |
| --- |
|  |

**FAMILY INFORMATION/HISTORY**

Learning is complex, it is helpful to know if other family members have struggled in these areas.

|  |  |
| --- | --- |
| What is your primary language? |  |
| Are any other languages spoken in the home? |  |
| Father’s occupation: | Mother’s occupation: |
| Father’s highest level of education:(Place X next to highest level that applies)Graduated High school:Bachelor’s Degree:Master’s Degree or higher: | Mother’s highest level of education:(Place X next to highest level that applies)Graduated High school:Bachelor’s Degree:Master’s Degree or higher: |
| Do you have any siblings with literacy or learning concerns: |  |

**People currently living within the household:**

|  |  |
| --- | --- |
| Name/relationship: | Age: |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Do any immediate or extended family members have a history of:**

|  |  |  |
| --- | --- | --- |
| Language delays/disabilities | YES  | NO |
| Learning disabilities | YES | NO |
| Dyslexia: | YES | NO |
| Attention disorders | YES | NO |
| Autism | YES | NO |
| If YES to any of the above please describe: |

**MEDICAL INFORMATION:**

|  |
| --- |
| Were you born prematurely? YES NOIf yes, how early?Did your mother experience any of the following during pregnancy: (please mark with an X and provide further explanation.) X-rays \_\_\_Medication \_\_\_Drug or alcohol problems\_\_\_Measles\_\_\_Surgery\_\_\_Chicken pox\_\_\_Toxemia\_\_\_Other: |
| Were there any complications during your mother’s pregnancy or your birth? YES NOIf yes, please explain: |
| Were there any medical problems detected at birth? YES NOIf yes, please describe: (consider breathing difficulties, jaundice, O2 needed, seizures, infections, feeding problems).Did you require a stay in the NICU ? YES NO |
| Have you had any serious illnesses, injuries or hospitalizations? YES NOIf yes, please describe: (consider high fevers, seizures, asthma, head injuries) |
| Do you have any medical diagnoses: YES NOIf yes, please describe:Are you currently taking any medications? |
| Has a vision test been completed in the last year? YES NOIf yes, does you need glasses? YES NOOther visual problems: |
| Did you have a history of ear infection or middle ear fluid? YES NOIf yes, did you have PE tubes placed? YES NOHave you been recently tested by an audiologist? YES NOIf yes please provide results of testing: |
| Have you ever been evaluated for Attention Deficit Disorder? YES NOResults if evaluated: |

**DEVELOPMENTAL HISTORY:**

To the best of your knowledge did your speech and language develop typically or are you aware of any delays?

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**Please list below what types of evaluations you had previously (e.g., speech and language, early intervention, developmental assessments, reading, neuropsychological, etc.).**

|  |  |  |
| --- | --- | --- |
| Type of evaluation | Where  | Date  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **Please send in copies of relevant evaluation reports.** |

|  |
| --- |
|  |

**EDUCATIONAL INFORMATION**

|  |
| --- |
| Where did you attend school? |
| What was the highest grade completed? |
| What type of classroom (regular, special education)? |
| Did you ever repeated a grade? YES NO |
| Did you receive any specialized services (Speech-language therapy, occupational therapy, physical therapy, reading, tutoring, other?If yes, describe the reason for this support, the frequency and duration?What was your highest level of education?Have you ever received extra time, or any other accommodations during classes or examinations?  |
| What are your favorite activities?What are your strengths? |

**EMPLOYMENT INFORMATION**

|  |
| --- |
| What is your present job or occupation? (or if you are currently in full-time education, what are you hoping to do when you leave?)Please list any jobs you have had:If you are not in work, what work or training are you interested in:In the work setting do you have problems with: Reading : YES NOUnderstanding what you read YES NOOrganization: YES NOSpelling: YES NOWritten work: YES NONote taking: YES NOWriting speed: YES NOLearning information: YES NONumbers: YES NO |

**WordsWorth SLP, LLC**

**PATIENT INFORMATION RELEASE**

PATIENT NAME (LAST, FIRST, MIDDLE)

BIRTHDATE TELEPHONE ALTERNATE PHONE

STREET ADDRESS

CITY STATE ZIP CODE

**PROVIDER**

Type of information to be released (Please be Specific)

**REQUESTOR**

**INFORMATION LIMITATIONS**

*List any restrictions to information to be released:*

I give permission to the PROVIDER to release Medical Record Information to the REQUESTOR concerning the MEDICAL CONDITION/INJURY described above which was diagnosed/treated during the stated TIME PERIOD. The information released will be restricted by any INFORMATION LIMITATIONS outlined above, and may be used only for the purpose described.

I understand that I can cancel this release at any time by notifying the PROVIDER in writing and that my cancellation will take effect when the PROVIDER receives my written notice. I understand that my cancellation will not have any effect on information released before the PROVIDER received my written notice.

Signature of Person Releasing Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Person Releasing Information (Please Print):

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WordsWorth SLP, LLC**

**CONSENT TO COMPLY WITH FEDERAL HIPAA ACT**

Patient Consent for Use and Disclosure of Protected Health Information

With my consent and signature, WordsWorth Speech Language Pathology may use and disclose protected health information about me to:

1. Carry out treatment, payment, and healthcare operations (services).
2. Call my home or other designated locations and leave a message on voice mail in reference to any items (i.e. appointment reminders, insurance forms, references to clinical care of laboratory results, etc.) that will assist in the practice of my medical care.
3. Mail to my home or other designated address any item (i.e. appointment reminder cards, patient financial statements, etc.) that will assist in practice of my medical care. Such correspondence is to be marked personal or confidential.
4. Send or transmit email to any location provided by me for all above similar items or purposes.
5. To use and/or disclose protected health information about me to/with third parties involved in my care. Such parties may include, but are not limited to, insurance companies, hospitals, specialty physicians and laboratory personnel. I may specifically describe the type of information (i.e. dates of services, level of detail, origin of information, et.c) subject to disclosure and may revoke this permission at a time and date chosen by me. By providing a written statement to the privacy office of WordsWorth Speech Language Pathology, I may revoke this permission; however, WordsWorth Speech Language Pathology may decline to provide further treatment to me. WordsWorth Speech Language Pathology may also decline further treatment to me should my restrictions on the type of third party information, in the WordsWorth Speech Language Pathology practitioners’ opinion, impede my medical care.

I have the right to request that WordsWorth Speech Language Pathology restrict how it uses or discloses my health information. However, as stated previously, WordsWorth Speech Language Pathology is not required to agree to my restrictions. If WordsWorth Speech Language Pathology accepts my restrictions, WordsWorth Speech Language Pathology is then bound by the restriction in the agreement, setting forth the restriction information until providing me, in writing, a cessation of such agreement.

I may revoke this entire consent, in writing, at any time. If I do not sign this consent or revoke this consent, WordsWorth Speech Language Pathology, in their sole discretion, may decline further treatment for me.

The HIPAA Privacy Act of 2001 was created to protect my health information. I understand this must be accomplished within the provisions and rules set up by WordsWorth Speech Language Pathology to fulfill federal law.WordsWorth Speech Language Pathology will comply with this law to preserve privacy. If compliance with this law impedes the medical care of the patient, WordsWorth Speech Language Pathology may decline to provide further care. WordsWorth Speech Language Pathology will strive to provide information so that I may make an informed decision concerning the privacy of my medical information.

**WordsWorth SLP, LLC**

**Acknowledgement of Health Information Practices**

**HIPAA Information form is available for review above. This information will be available to you at your first appointment as well.**

WordsWorth SLP, LLC are committed to protecting their clients and patients’ health information. By signing below, I acknowledge that I have received the Notice of Health Information Practices.

I consent to the release of my health information to be used for the treatment, payment and health care operations of WordsWorth SLP, LLC.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print client’s name Parent/Responsible party name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client (if older than 18) or Date
Parent or Responsible party.

**WordsWorth SLP, LLC**

**Attendance and Payment for Services Agreement**

As private practice clinic, it is very important that clients attend their scheduled sessions. Frequent “no shows” or late cancellations not only hurt the client’s progress, but they make it difficult to keep rates affordable or to schedule other clients who are waitlisted for services.

Therefore, ask you to read and indicate your agreement with our clinic attendance and payment policy by signing this form. Exceptions to this policy can only be made with prior approval.

**Cancelations for evaluations:**

1. Please be advised that you must send a deposit of $100 within seven days of booking your evaluation appointment to hold the time slot. This fee is to review your records and communicate prior to the evaluation. If you must cancel your appointment, you must do so 72 hours (three days) before the appointment to receive your deposit back (minus the time already taken to review your files, records, etc.) If you fail to cancel your appointment within that time frame or if you miss the appointment, you will forfeit your deposit.

**Cancelations for therapy sessions:**

1. Non-emergency cancellations require 24 hours' notice. Non-emergencies include vacations, preplanned medical appointments, family events, parties, sports events, lack of babysitter or anything that is not designated as "emergency" (see below). The session must be canceled no later than 24 hours before the appointment. If non-emergency cancellations become excessive, the client may lose his or her weekly slot in the clinician's schedule. If the session is not canceled with 24 hours' notice it will be billed at the regular session rate.
2. Emergency cancellations are accepted only for illness, illness of a family member or death in the family. These sessions must be canceled by 8:00 a.m. on the day of the appointment. Please do not come, to the office with a fever, strep, unidentified rash, diarrhea, vomiting or any highly contagious illness. You must be fever-free for 24 hours prior to the session. If you arrive ill, you will be dismissed and charged for the session.
3. WordsWorth will offer make-up sessions, as they are in the client's best interest. Make-up slots are offered for inclement weather, illness and pre-arranged vacations/holidays. Make-up sessions are not offered when there is a violation of the cancellation policy. For example, if you are charged for a no-show, we will not reschedule that visit. Make-ups should be attempted for all holidays, vacations and cancellations. Failure to attempt to schedule make-ups is considered a violation of policies.
4. Because this office holds a time for your session, you are essentially promising to fulfill that slot. If you exceed a cancellation rate of 25 percent or higher you will receive a written notice that your slot is in jeopardy, especially if you do not schedule or attend make-up sessions. This policy includes emergency, non-emergency and vacation cancellations.
5. If you plan on discontinuing services for any reason, you must give this office four weeks' notice or you will be billed for the missed sessions. This office must also give you 30 days' notice if treatment will be discontinued for breach of attendance policy.

**Payments:**

1. Payment is expected at the time of services.
2. A $10 discount will be provided for every 6sessions paid for in advance.
3. Fees for cancellation within 24 hours or failure to show for appointments will be taken from the unused portion of advance payments.

***I have read, understand and agree to all the information contained in this policy statement.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client (if older than 18), Date
Parent or Responsible party.