Dear Parent/Guardian,

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

* If your child has 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 child’s needs.
* If your child currently has an **Individualized Educational Program (IEP)** in place**, or 504 Plan in place, please include a copy with the intake form**.
* Please leave other children at home as you may need to be in the room with your child. Consider bringing a drink and snack for your child.
* Please review our **Attendance and Payment for Services Agreement** and bring this to your child’s 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 complete all four forms and submit these to WordsWorth via mail or email at least one week prior to your child’s first appointment.**

I look forward to working with you and your child.

Lesley Pech MA, CCC-SLP, CBIS

Speech Language Pathologist

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

**Speech and Language Evaluation Intake Questionnaire**

**and Case History Form**

|  |  |
| --- | --- |
| Child’s name (use initials only if not hand delivered): | Date of birth: |
| Sex: | Age: |
| Home address: (If parents do not reside at the same address please provide both addresses if custody is shared.) |
| Referred by: | Parents’ contact information: (Please provide best emergency contact number)Mother’s Name: Email:Phone:May we leave private information on this phone number/email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Father ’s Name: Email:Phone:May we leave private information on this phone number/email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Questionnaire filled out by:Relationship to child: |
| Primary Physician’s name:Name of practice:Address: Phone number: |
| School name: Teacher’s name: |

**Describe specific concerns regarding your child’s language and or literacy challenges:**

|  |
| --- |
|  |

**FAMILY INFORMATION/HISTORY**

|  |  |
| --- | --- |
| What is the child’s primary language? |  |
| Are any other languages spoken in the home? |  |
| Father’s marital status: | Mother’s marital status: |
| 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: |
| Are there 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:**

|  |
| --- |
| Is this your biological child? YES NOWas the pregnancy full term? YES NOIf no, how long?Did the 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 pregnancy or delivery? 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 your child require a stay in the NICU ? YES NO |
| Has your child had any serious illnesses, injuries or hospitalizations? YES NOIf yes, please describe: (consider high fevers, seizures, asthma, head injuries) |
| Does your child have any medical diagnoses: YES NOIf yes, please describe:Is your child currently taking any medications? |
| Has a vision test been completed in the last 6 months? YES NOIf yes, does your child need glasses? YES NOOther visual problems: |
| Does your child have a history of ear infection or middle ear fluid? YES NOIf yes, did your child have PE tubes placed? YES NOHas your child been recently tested by an audiologist? YES NOIf yes please provide results of testing: |
| Has your child been evaluated for Attention Deficit Disorder? YES NOResults if evaluated: |

**DEVELOPMENTAL HISTORY:**

To the best of your ability, please list the ages your child achieved the following developmental milestones:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| SKILL | YES | NO | AGE ACHIEVED | NOT KNOWN |
| Sat independently by 12 months |  |  |  |  |
| Ate solid food by 12 months |  |  |  |  |
| Feed self by 2 years |  |  |  |  |
| Cooing/babbling by 4 months |  |  |  |  |
| Respond to name/Peek-a-boo by 8 months |  |  |  |  |
| Said first word by 15 months |  |  |  |  |
| Combined two words by 24 months |  |  |  |  |
| Produced short sentences by 36 months |  |  |  |  |

**Please list below what types of evaluations the child has had (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**

**Please send a copy of current IEP and recent IEP progress report if applicable.**

|  |
| --- |
| Where does your child receive schooling? |
| What grade is your child in? |
| What type of classroom (regular, special education)? |
| Has your child ever repeated a grade? YES NO |
| Does your child receive any specialized services (Speech-language therapy, occupational therapy, physical therapy, reading, tutoring, other?If yes, describe the reason for this support and the frequency? |
| Do you have concerns about your child’s reading or academic progress? YES NOIf yes, please explain: |
| What are your child’s favorite activities? |
| What are your child’s strengths? |

**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 or my child 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 medical care for me or my child.
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 medical care for me or my child. 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 or my child to/with third parties involved in mine or my child’s 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 or my child. WordsWorth Speech Language Pathology may also decline further treatment to me or my child should my restrictions on the type of third party information, in the WordsWorth Speech Language Pathology practitioners’ opinion, impede medical care of my child.

I have the right to request that WordsWorth Speech Language Pathology restrict how it uses or discloses mine or my child’s 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 or my child.

The HIPAA Privacy Act of 2001 was created to protect mine and my child’s 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 mine or my child’s 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 12:00 p.m. on the day of the appointment. Please do not come, or bring your child, to the office with a fever, strep, unidentified rash, diarrhea, vomiting or any highly contagious illness. Your child must be fever-free for 24 hours prior to the session. If your child arrives 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.