Achieve
SPEECH THERAPY

4141 B Street, Suite 202
Anchorage, AK 99503
E: yvonnesj@gmail.com
P: (907) 727-0935
F: (907) 331-0507

CHILD INTAKE FORM

To Parent/Guardian: Please answer the following questions about your child. **Please attach copies of the following documents:**

- Speech-language evaluations, hearing tests, recent medical physical, and/or relevant medical evaluations (e.g., autism diagnosis).
- Goals that are currently/were previously targeted in therapy (including physical therapy, occupational therapy, or other speech services).
- PLEASE RETURN THIS INFORMATION TO YOUR THERAPIST BEFORE SCHEDULING YOUR EVALUATION.

CHILD'S INFORMATION			
FULL NAME	GENDER ☐ Male ☐ Female		DOB
CURRENT AGE	NAME OF SCHOOL		GRADE
PRIMARY CARE PHYSICIAN (PCP)		PCP PHONE	
DESCRIBE YOUR MAIN CONCERNS Include <u>when</u> the problem was first noticed, <u>who</u> noticed it, and <u>where</u> the problem occurs.			
How does your child react to being misunderstood or unable to communicate?	☐ Tries again/revises ☐ Becomes angry/frustrated ☐Other: ☐ Gives up ☐ Doesn't notice		
Why are you seeking speech-language services for your child?			
Has your child's physician noticed these concerns? If yes, what were his/her recommendations?			
How did you learn about us?			
In the table to the right, list all other services your child has received, including counseling; psychiatry; physical, occupational, or speech therapy. If none, check below. ☐ None	TYPE OF SERVICE	DATES/AGE	NAME OF PROVIDER

Continue to next page.

FAMILY'S INFORMATION

With whom does your child live? (Check all that apply)	☐ Biological parent(s) ☐ Adoptive parent(s) ☐ Legal guardian(s) ☐ Grandparent(s) ☐ Sibling(s) ☐ Other:

In the table to the right, list all family members who live in the same home as your child.	NAME	AGE	RELATION TO CHILD

Do you have any family pets? (List name and type)	

PARENT/LEGAL GUARDIAN INFORMATION

FULL NAME		GENDER ☐ Male ☐ Female	DOB
ADDRESS		CITY	ZIP
PHONE 1	☐ CELL ☐ HOME ☐ WORK	EMAIL	
PHONE 2	☐ CELL ☐ HOME ☐ WORK	PREFERRED METHOD OF CONTACT	☐ PHONE 1 ☐ EMAIL ☐ PHONE 2
PLACE OF EMPLOYMENT		POSITION	

PARENT 2 INFORMATION

FULL NAME		GENDER ☐ Male ☐ Female	DOB
ADDRESS		CITY	ZIP
PHONE 1	☐ CELL ☐ HOME ☐ WORK	EMAIL	
PHONE 2	☐ CELL ☐ HOME ☐ WORK	PREFERRED METHOD OF CONTACT	☐ PHONE 1 ☐ EMAIL ☐ PHONE 2
PLACE OF EMPLOYMENT		POSITION	

Are there family circumstances that would be helpful to share with your child's therapist? (e.g., custody arrangements)	
Are there any other languages spoken in the home? If yes, which language(s) and how often?	

Do any other family members have speech, language, or related difficulties or disorders? (e.g., ADHD, autism)	RELATION TO CHILD	RELATED DIAGNOSIS/DISORDER

CHILD'S HEALTH BACKGROUND

Describe your pregnancy, including any complications.	
Describe your labor/delivery, including any complications.	

TYPE OF BIRTH (check all that apply) ☐ Spontaneous (not induced) ☐ Induced ☐ Vaginal ☐ C-section

BIRTH PLACE (hospital/birth center)		BIRTH ATTENDANT (physician, midwife)	
GESTATIONAL AGE (in weeks)	BIRTH WEIGHT	BIRTH LENGTH	NICU ☐ Yes ☐ No How long?

Were there any complications after birth or during the first few weeks?	☐ Difficulty breathing ☐ Difficulty feeding ☐ Birth defect ☐ Jaundice ☐ Seizures ☐ Other:

Has your child's hearing been tested? ☐ Yes ☐ No If yes, when and where? ☐ Passed ☐ Did not pass

Describe any serious illnesses, injuries, or medical procedures your child has experienced.	
List any environmental or food allergies.	
List any routine medications your child is currently taking or has taken long term.	
Describe any other conditions or diagnoses identified by your child's doctor or other professionals.	

CHILD'S FEEDING DEVELOPMENT

BREASTFED from _____ months until _____ months	FORMULA FED from _____ months until _____ months	BOTTLE until _____

At what age did your child begin using the following?	☐ SIPPY CUP _____ months ☐ STRAW _____ months ☐ OPEN CUP _____ months ☐ UTENSILS _____ months
Describe any difficulties with sucking, swallowing, chewing, eating different textures, etc.	

FAVORITE FOODS	FOOD AVERSIONS

CHILD'S SPEECH AND LANGUAGE DEVELOPMENT	
At what age did your child begin:	☐ BABBLING (bababa) _____ months ☐ JARGON (bada bama) _____ months ☐ FIRST WORD_____ at _____ months ☐ TWO-WORD COMBO (more milk) _____ months ☐ THREE-WORD COMBO _____ months/years ☐ SENTENCES _____ months/years ☐ READING LETTERS _____ years ☐ WRITING LETTERS _____ years ☐ READING WORDS _____ years ☐ WRITING WORDS _____ years ☐ READING SENTENCES _____ years ☐ WRITING SENTENCES _____ years
Who understands your child's speech, and how much do they understand? 25% = 1 out of 4 words understood 50% = 2 out of 4 words understood 75% = 3 out of 4 words understood 100% = 4 out of 4 words understood	☐ Parent(s) _____% ☐ Sibling(s) _____% ☐ Peers _____% ☐ Teacher(s) _____% ☐ Extended Family _____% ☐ Strangers _____%
Has your child's speech-language been evaluated before? If yes, please note the place and summarize the findings.	
What are a few specific goals or skills you would like your child to attain in speech therapy?	
Is your child aware of his/her communication difficulties? Do you wish to share information with your child, such as goals or diagnosis?	

CHILD'S STRENGTHS AND FAVORITES	
Describe your child's strongest skills and personality traits. What makes your child unique?	
FAVORITE ACTIVITIES / HOBBIES	
FAVORITE TOYS	
FAVORITE MOVIES	
FAVORITE BOOKS	

Thank you for taking the time to complete this information about your child.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

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Please check areas in which your child has difficulty or needs help:

Fine Motor Skills: ☐ Management of clothing fasteners ☐ Ability to tie shoes ☐ Scissors skills ☐ Pencil grasp ☐ Coloring accuracy ☐ Ability to open snack and drink containers ☐ Sharpening pencil	Functional School Skills: ☐ Management of clothing in bathroom ☐ Management of coat/mittens/hat ☐ Management of backpack/lunchbox ☐ Walks with tray in cafeteria ☐ Ability to handle transitions
Body in Space Skills: ☐ Ability to stay seated in chair ☐ Sitting tolerance on floor ☐ Waiting/walking in line ☐ Navigating playground ☐ Space between self and others in line	Visual Motor/Visual Perceptual: ☐ Legibility of handwriting ☐ Fluidity of handwriting ☐ Ease of getting thoughts on paper ☐ Quality of drawings ☐ Quality of pencil pressure ☐ Frequency of letter/ Number reversals
Sensory Processing Skills: ☐ Tolerance of noise ☐ Tolerance of tactile sensations ☐ Tolerance of movement ☐ Engages on self-stimulatory behavior ☐ Ability to plan new movement patterns	Activities of Daily Living: ☐ Help with dressing ☐ Shoe tying ☐ Hair combing, tooth brushing ☐ Eating with/without utensils ☐ Bathing ☐ Toileting/potty training
Gross Motor Skills: ☐ Difficulty with running, jumping, hopping ☐ Difficulty with ball skills: catching, kicking ☐ Poor sitting balance in chair, on floor ☐ Poor performance in physical education classes ☐ On playground fatigues easily/becomes short of breath	Equipment: ☐ Needs training in wheelchair propulsion ☐ Needs positioning equipment for sitting, feeding ☐ Uses walker, crutches, foot/leg, orthotics ☐ Equipment in need of repair
Gait/Balance: ☐ Difficulty walking: awkward gait, walks on toes ☐ Falls frequently ☐ Difficulty with stairs on bus, curbs, etc ☐ Needs assistance to walk ☐ Uses assistive devices _____	Developmental Milestones: ☐ Held head up at _____ months ☐ Sat at _____ months ☐ Rolled over at _____ months ☐ Crawled at _____ months ☐ Pulled to stand at _____ months ☐ Walked at _____ months

Print Child's Name_____ DOB _____

Parent/Legal Guardian Signature_____Date _____

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Patient History Questionnaire

Patient Name: _____Sex: _____ DOB/Age: _____

Address:_____

_____

Patient Phone: _____Diagnosis_____

Parent/Guardian Information:

Name: _____
Relationship:_____
Address:_____
_____
_____
Phone:_____

Email / Work Information:

Employer:_____
Email: _____
Phone:_____
Employer:_____
Email: _____
Phone:_____

Insurance Information #1

Insured Name:_____
Insured SSN:_____
Group Name:_____
Group Number: _____
Insured's Address, if different from Patient:
_____
_____
Policy #:_____
Relation to Pt._____
Insured's Date of Birth:_____

Insurance Information #2

Insured Name:_____
Insured SSN:_____
Group Name:_____
Group Number: _____
Insured's Address, if different from Patient:
_____
_____
Policy #:_____
Relation to Pt._____
Insured's Date of Birth:_____

Primary Care Physician Information

Name:_____
Phone:_____Fax:_____

Emergency Contact

Name: _____
Phone:_____

I certify that this information is true and correct to the best of my knowledge. I will notify Achieve Speech Therapy of any changes in the above information within 30 days. I hereby authorize Achieve Speech Therapy to furnish the insured's insurance company all information which may be requested concerning my child. I hereby assign Achieve Speech Therapy any money for which I am paid for medical expenses related to services performed at the clinic.

_____

Parent/Guardian Signature

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Release or Obtain Medical Information

I authorize Achieve Speech Therapy LLC to release and/or obtain any or all pertinent educational records and/or medical information to or from the providers listed below to maintain quality of care. Furthermore, I authorize Achieve Speech Therapy to release information to insurance providers to coordinate payment of benefits.

I understand that I have the right to revoke this authorization by written request at any time, except if the program or person, which is to make the disclosure, has already acted on it.

I understand that authorizing the disclosure of this information is voluntary, and I do not need to sign his form in order "to be eligible for evaluation."

I understand that I have the right to copy and inspect the information to be disclosed.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

PLEASE ENTER NAME AND NUMBER OF EACH

Pediatrician: _____

Case Manager: _____

Other agencies/therapists (OT/PT/SLP/DT): _____

Hospitals/Clinics/Health Departments: _____

School: _____

CDSA: _____

Neurologist: _____

Developmental Pediatrician: _____

Opthomologist/Optometrist: _____

Social Worker: _____

Psychologist: _____

Other: _____

Parent initials_____

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Release or Request of Medical Information

I acknowledge receipt of information and the Notice of Privacy Practices between Achieve Speech Therapy and the above named agencies/facilities and understand the conditions under which information will be used and disclosed. I understand the types of information that may be disclosed to the above named persons. This authorization will be in effect until discharge. I understand that I can add to or remove authorization of any person at any time in writing to Achieve Speech Therapy. I understand that I have the right to revoke this authorization by written request at any time, except if the program or person, which is to make the disclosure, has already acted on it.

I understand that authorizing the disclosure of this information is voluntary, and I do not need to sign this form in order to be eligible for evaluation/therapy. I understand that I have the right to copy and inspect the information to be disclosed. However, we will not be able to treat without disclosure.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Patient Name:
_____

_____
Signature
(Parent/Guardian/Legal Representative) Date

Records/information should be sent to:

Achieve Speech Therapy LLC, at Fax # 907-331-0507

Or Copy following link: https://sendsafe.to/Yvonnesj@gmail.com

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TREATMENT CONSENT FORM

Child's Name:_____

I,_____(Parent or legal guardian) gives my consent for Achieve Speech Therapy to provide the services listed below:

☐ Evaluation ☐ Treatment ☐ Other (Please specify): _____

I allow this treatment to be performed at the following treatment sites:

☐ Office ☐ Daycare ☐ School ☐ Home

Authorization for Supervision during Therapy Sessions:

The following people may be present in the absence of the parent/guardian during therapy sessions:

_____

Parent Signature:_____ Date: _____

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PROTECTED HEALTH INFORMATION (PHI)

I consent for Achieve Speech Therapy to use the patient's Protected Health Information (PHI) for the purpose of providing treatment, payment of services, and for Achieve Speech Therapy general healthcare operations purposes. PHI means for any information, including demographic information, created or received by Achieve Speech Therapy that relates to past, present or future health conditions: information that relates to the provision of health care; information that relates to past, present or future payment for the provision of health care services; and information that can be used to identify the patient.

I have received the notice for Privacy Practices and understand the conditions under which information will be used and disclosed.

Signature:_____Date: _____

I have received the Achieve Speech Therapy Policy regarding my Health Information Rights under HIPAA, CFR §164.524.

Signature:_____Date: _____

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Patient Billing Information/ Financial Policy

I hereby authorize Achieve Speech Therapy to charge my credit card for my child's Speech Therapy services.

I understand that Achieve Speech Therapy financial policy states that I am required to have a credit card authorization on file to process co-pays for services. **See financial policy referencing co-insurance, copays, and deductibles.*

Signature:_____Date: _____

Credit Card Authorization

Card Type:

Patient's Name: _____

- ◯ Visa
- ◯ MasterCard
- ◯ HSA
- ◯ Debit

Name as it appears on card: _____

Credit Card Number: _____

Verification Code (last three digits on signature panel): _____ Expiration Date: _____

Zip Code of billing address: _____

Authorization for Billing and Payment of Services:

I authorize Achieve Speech Therapy to contact Medicaid and/or private insurance company to confirm benefits and release information necessary to process claims. I authorize payment directly to Achieve Speech Therapy for services rendered. I understand that I am responsible for any co-pay/co-insurance and/or deductible amounts associated with the patient's benefits. *I understand that it is my responsibility to know my benefits and that verification of benefits by Achieve Speech Therapy is not a guarantee of payment.*

Signature:_____Date_____

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***Financial Policy and Consent**

- It is required that all patients be accompanied by a parent or legal guardian at the time of the initial visit.
- We require a 24-HOUR ADVANCED NOTICE FOR ALL CANCELLATIONS.
- Three no-show appointments over a three month period will result in a discontinuation of services.
- If you arrive late for your scheduled appointment time, you may be required to reschedule so that other patients are not inconvenienced.
- Co-payments, if dictated by your insurance policy, are due at the time of service.
- Patients will be responsible for the remainder of their bill not paid by insurance.
- Payments must be made within 30 days of receipt of statement. A credit card, provided at the time of the initial visit, will be billed for statements more than 45 days late, unless previous payment arrangements are made.
- 15% interest will be applied to all payments that are not made within 60 days of statement.
- Statements not paid within 30 days will result in an immediate discharge from therapy.
- Statements not paid within 90 days are subject to collections.
- All checks returned to us for non-sufficient funds will result in a $35 processing fee. The original check amount plus the processing fee must be paid at your next appointment or within 10 days.

Patients Rights and Responsibilities

- Be treated with respect to and have the right to privacy
- Receive care that is considerate and respects my personal values and belief system
- Personal privacy and confidentiality of information
- Reasonable access to care, regardless of my race, religion, gender, ethnicity, age or disability
- Participate in an informed way in the decision making process, regarding treatment planning and implementation of services, from referral to discharge
- Discuss with treating professionals appropriate or medically necessary treatment options for my child's condition, regardless of cost or benefit coverage
- Services provided in the most appropriate and least restrictive manner
- Receive assessment and treatment information in an understandable manner
- Accept or refuse services and the right to refuse to participate in research programs and projects
- The right to file a grievance regarding violations of your human rights and receive a timely response
- The right to individualized programming and sensitive treatment practices
- Request information regarding the qualifications of staff members who provide your services
- Transition services as necessary and appropriate

I understand that I am responsible for: Achieve Speech Therapy

- Providing (to the extent possible) the treating therapist(s) with information needed in order to receive appropriate care
- Following plans and instructions for care that I have agreed upon with the treating therapist(s)
- Understanding my health problems and participating, to the degree possible, in developing, with the treating therapist(s), mutually agreed upon treatment goals
- Payment of the balance of treatment services not covered by insurance

I AGREE AND CONSENT TO PARTICIPATE IN THE THERAPY SERVICES OFFERED AND PROVIDED BY ACHIEVE SPEECH THERAPY. I UNDERSTAND THAT I AM CONSENTING AND AGREEING TO THOSE SERVICES.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OF ACHIEVE SPEECH THERAPY CLINIC.

I HAVE READ AND UNDERSTAND THE PATIENT RIGHTS AND RESPONSIBILITIES.

Responsible Party Signature: _____Print Your Name: _____

Childs Name: _____Date of Birth: _____

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ATTENDANCE/CANCELLATION POLICY

Achieve Speech Therapy takes the care of our patients and their families very seriously. It is very important to us that you attend your regularly scheduled appointments. These scheduled appointments are part of a recommended treatment plan aimed at improving health, function, and the overall quality of life of our patients. Without regularly attending your scheduled appointments, the benefits of therapy will be limited. In addition, several children are waiting to receive therapy services during optimal times such as afternoons following school or in the evenings when parents are home from work. Due to the high number of individuals in need of these times Achieve Speech Therapy, would like to make every effort to accommodate those in need and who are available to make their appointment times.

If you need to cancel your visit, please inform your therapist as soon as possible, and more than 4 hours in advance. However, we understand that occasionally emergencies arise or children become suddenly ill, etc. Please notify us as soon as you are aware that your child will not be attending his/her therapy session for these reasons. This will allow us to plan our schedules accordingly. *We will make every effort to reschedule your visit in the same week if possible.*

If no prior cancellation is made, or cancellation occurs with less than 24 hour notice (with the exception of illness/emergencies) a $50.00 fee will be charged. Achieve Speech Therapy also reserves the right to discharge your child after three missed sessions without prior cancellation.

Child's Name (please print): _____

Parent Signature:_____Date: _____

CHILD ILLNESS POLICY

Please keep your child home from therapy under the following conditions:

- Fever/vomiting within the past 24 hours (this includes a low grade temperature)
- Highly contagious conditions, including the flu, stomach virus, diarrhea, conjunctivitis (pink eye), head lice, ring worm, etc.
- Severe respiratory problems (i.e. thick or odd-colored nasal discharge, sever coughing, etc.)

Please notify your therapist if your child has been exposed to/contracted any contagious illnesses, for example; strep throat, fifth's disease, chicken pox, etc.

Thanks for helping us minimize the spread of illnesses to our therapists and other patients!

Parent Signature:_____Date: _____

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HIPAA PRIVACY POLICY

Your privacy matters: In 1996, Congress passed legislation to provide continuity of coverage when individuals switch health plans and to ensure the security and privacy of protected health information. ACHIEVE SPEECH THERAPY has always been committed to protecting individuals' health information and will continue its commitment by ensuring compliance with the **Health Insurance Portability and Accountability Act (HIPAA)** privacy requirements.

This rule – the first federal rule to protect the privacy of health information –establishes basic national privacy standards for healthcare providers, health plans and healthcare clearinghouses to follow, in order to protect patients and encourage them to seek needed care. The HIPAA Privacy Rule grants healthcare consumers several rights regarding their privacy and protected health information. Achieve Speech Therapy has instituted documents, policies and procedures that address these rights.

These include the right to: Receive Achieve Speech Therapy's **Written Notice of Privacy Practices**, which details individual rights and provides examples about how health information is used for treatment, payment, and health care operations.

- Request a restriction on specific uses and disclosures of protected health information.
- Receive confidential communications of health information.
- Access, inspect and copy protected health information.
- Request amendment and/or correction of protected health information.
- Receive an accounting of disclosures of protected health information.
- File a complaint with Achieve SpeechTherapy and with The Department of Health and Human Services (DHHS).

What Achieve Speech Therapy is doing to protect your privacy: Achieve Speech Therapy has taken a very active role to ensure that your right to protected health information is recognized.

We have prepared a **Notice of Privacy Practices** for you. This document tells you what we do with your health information and what your rights are. This document is available during registration or you may request your own by calling 907-727-0935 and asking for a copy of the Notice of Privacy Practices.

Privacy Fact Sheets available to consumers: The Department of Health and Human Services (DHHS) Office for Civil Rights (OCR) privacy listserv offers two fact sheets available on its Web site. The first, *"Privacy and Your Health Information,"* provides a general overview of the HIPAA privacy rule and individual rights associated with the rule. The second, *"Your Health Information Privacy Rights,"* focuses on each of the privacy rights included under the rule. Both sheets can be obtained from the OCR Web site at **http://www.hhs.gov/ocr/hipaa/**

I have received and read Achieve Speech Therapy's HIPAA Policy.

Patient Name (printed): _____ Date of Birth: _____
Parent/Guardian Signature:_____ Date:_____

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Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclose personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(II), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1196 (the "Privacy Regulations").

Please read the following information carefully:

1 I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Achieve Speech Therapy (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2 I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3 I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 5465 Route 8, Gibsonia, PA 15044, Attention: Practice Compliance Director

4 I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me, but if the Practice agrees to such a requested restriction it will be bound by the restriction until I notify it otherwise in writing.

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions):

_____

_____

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

_____ _____

Signature of Guardian Date

_____

Patient's Name

_____

Date of Birth

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