Susan Houston M.S. CCC-SLP

6425 Living Place, Suite #200
Pittsburgh, PA 15206

Emerge
SPEECH & LANGUAGE

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SPEECH THERAPY INTAKE FORM

CLIENT INFORMATION

Person completing form: _____

Relationship to child: _____ Date: _____

Child's name: _____ DOB: _____ Gender: _____

How did you hear about our clinic? _____

Thank you for taking the time to fill out this form as completely and accurately as possible. We value your role in the evaluation process to help us determine the most appropriate treatment for your child. All responses are confidential and will not be released without your permission. Please answer to the best of your knowledge and mark "N/A" for any questions that do not apply to your child.

MEDICAL INFORMATION

Child's primary care physician: _____ Date of last doctor's visit (approx.): _____

Is your child currently under the care of any other medical specialists *(such as a neurologist or audiologist)*? If so, please list:

_____

Please list any medical diagnoses your child has: _____

Please list any medications your child currently takes: _____

Please list any allergies your child has: _____

Please describe any developmental delays your child is currently experiencing or has experienced in the past *(such as delays with walking, saying first words, potty training, etc.)*:

_____

Were there any birth or pregnancy complications? _____

Is there a family history of speech-language delays or disorders, autism, learning disabilities, or mental health diagnoses? If so, please describe:

_____

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SOCIAL/EDUCATIONAL INFORMATION

Does your child attend school or daycare? _____ Current grade: _____

Grades repeated? _____ School or daycare name: _____

Special services received at school *(such as special education classes, speech therapy, occupational therapy, physical therapy)*:

_____

Special services received outside of school *(such as speech therapy at a clinic, ABA therapy, hippotherapy)*:

_____

Does your child experience difficulties at school *(socially or academically)*? If so, please describe:

_____

Has your child's teacher mentioned concerns about their speech/language skills, social skills, behavior, or academics? _____

FAMILY INFORMATION

Parent's Name: _____ Best contact phone #: _____

Parent's Name: _____ Best contact phone #: _____

If applicable, please list other family members who regularly care for your child:

_____

Please list family members that your child lives with, including siblings and their ages:

_____

Which language(s) is/are spoken in the home? _____

Which language(s) does your child speak? _____

SPEECH AND LANGUAGE DEVELOPMENT

At what age did your child begin babbling? _____

At what age did your child say their first words? _____

At what age did your child begin speaking in sentences? _____

At what age did your child begin engaging in conversation? _____

Approximately how much of your child's speech do others understand? _____

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SPEECH/LANGUAGE/SWALLOWING CONCERNS

Do you have concerns about the way your child pronounces words, or about your child's ability to be understood?

Does your child have difficulty understanding what is said to them?

Does your child have difficulty expressing themselves *(such as forgetting words, incorrect grammar, or difficulty retelling a story)*?

Does your child stutter or repeat words multiple times when trying to speak?

Do you have concerns with your child's voice quality *(such as chronic hoarseness or breathiness)*?

Does your child have difficulty with feeding, chewing, or swallowing?

Do you have any additional concerns about your child's speech, language, swallowing, or communication skills?

INTEREST INVENTORY

What are your child's interests and favorite activities?

Does your child have any strong fears *(such as stuffed animals or loud noises)*?

Is there anything else you would like us to know about your child?

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HIPAA PRIVACY NOTICE

This HIPAA (Health Insurance Portability and Accountability Act) Notice describes how speech-language therapy information and other relevant medical information about you/your child may be used and disclosed and how you can get access to this information. Please review it carefully.

COMMITMENT TO PRIVACY

We are dedicated to protecting your privacy and health information. In serving our patients, and to comply with applicable laws, we create records regarding evaluation and treatment. We are required to keep this information safe and secure. We will only share your information in accordance with state or federal law and in keeping with ethical standards of practice.

TYPES OF PERSONAL HEALTH INFORMATION WE MAY COLLECT AND STORE:

- Notes from doctors, teachers, or other healthcare providers
- Evaluation results
- Treatment plan, notes, and results
- Medical history
- Insurance information

HOW WE MIGHT USE AND SHARE THIS INFORMATION:

- To provide treatment
- To share with other medical professionals involved in your care
- To run our practice, including billing for services
- To do research or help with public health and safety issues
- To comply with the law, including disclosures if abuse or neglect is suspected

YOU HAVE THE RIGHT TO:

- Receive a copy of your paper or electronic treatment records
- Request corrections to information collected about you
- Request confidential communication
- Ask us to limit the information we share (especially with regard to how information is shared with your friends and family or when marketing our services)
- File a complaint if you feel your information has been shared in a way that violates HIPAA policies

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Requests must be made in writing and not all requests can or will be fulfilled.

We must inform you before we share your medical information in a way that is not mentioned in this notice.

This HIPAA policy is subject to change and we will provide you a copy of the updated notice.

If you have any questions, please ask your speech-language pathologist.

I have read and understood the privacy policies disclosed in this notice.

Your Signature: _____ Date: _____

Printed Name: _____

Child's Name: _____ Relationship to Child: _____

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FINANCIAL AGREEMENT

Thank you for choosing Emerge Speech & Language, LLC. Please note that Emerge Speech & Language, LLC is a private pay practice at this time and does not directly accept insurance. We will however provide documentation when requested for reimbursement by your insurance, in the form of a superbill. Clients are responsible for confirming insurance coverage and handling all reimbursement. Please note that all insurance companies vary and speech-language therapy services may or may not be a covered benefit by your insurance.

FEE SCHEDULE

- Evaluation: $185 includes a comprehensive speech and language assessment as well as treatment plan.
- Therapy Sessions: $80 for a 30 minute session. $95 for a 50 minute session.

All payment for services is required at the time services are rendered. We accept payment by cash, personal check, Health Savings Account (HSA), or credit card (Visa, MasterCard, American Express, Discover). There is a service charge of $25.00 for any returned check.

ACKNOWLEDGMENT

I, _____, acknowledge and accept complete responsibility for payment of all services rendered by Emerge Speech & Language, LLC. I understand that I am responsible for prompt payment of any cancellation or no-show fees incurred as outlined in the Attendance and Cancellation Policy. I have read, understand, and hereby agree to the Financial Policy of Emerge Speech & Language, LLC.

Your Signature: _____ Date: _____

Printed Name: _____

Child's Name: _____ Relationship to Child: _____

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ATTENDANCE POLICY

In order to better serve you and make quicker progress toward goals, regular attendance to therapy is imperative. Please thoroughly read and initial next to your responsibilities outlined as follows:

___ I am responsible for attending speech/language therapy sessions as scheduled. I understand that I must maintain at least an 80% attendance rate as measured within a given 3-month period or risk losing my appointment slot.

___ In the event of a cancellation, I will provide as much notice as possible. “Non-emergency” cancellations require 24 hours’ notice and include: vacations, pre-planned medical appointments, family events, parties, sports events, lack of babysitters, or anything that is not designated as an “emergency”. If the session is not canceled within 24-hour notice I understand I will be responsible for paying a $50 fee. At Emerge Speech & Language LLC we understand that sometimes illnesses or emergencies occur that may not allow you to give 24 hours notice. For emergency cancellations within 24 hours I understand that after 2 such cancellations, a $50 charge will be incurred for all subsequent emergency cancellations within a calendar year.

___ I understand that Emerge Speech & Language LLC may send me an email reminder the day before my scheduled appointment, as a courtesy. I recognize that my attendance is not dependent upon the receipt of an email reminder. The email below is my preferred email for receiving courtesy appointment reminders:

Email adress: _____

I have read, understand and agree to Emerge Speech & Language LLC’s Attendance and Cancellation Policy as outlined above.

Your Signature: _____ Date: _____

Printed Name: _____

Child’s Name: _____ Relationship to Child: _____

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CONSENT FOR SERVICES

Please complete the form below to grant permission and authorize a screening, comprehensive Speech language evaluation, and/or treatment (as needed) for your child. A screening is a brief assessment used to determine whether further evaluation is needed. Speech language evaluations consist of standardized testing, informal and formal observations, and clinical judgment.

You will be contacted regarding the results of the screening. A complete evaluation and/or subsequent treatment will only be administered after your therapist has discussed the results of the screening and any relevant fees or insurance considerations. If an evaluation is agreed upon, a state licensed and certified Speech language pathologist will administer the evaluation (including standardized evaluation tests, language samples, caregiver interviews, etc.).

If Speech language therapy is warranted, your therapist will discuss the planned treatment course for your child, informed by the evaluation results as well as parent/caregiver input.

If you have any questions, your therapist will be happy to discuss with you during this process.

By signing below, I authorize Emerge Speech & Language LLC to screen, evaluate and/ or provide the necessary speech and/or language therapy to my child.

Your Signature: _____ Date: _____

Printed Name: _____

Child's Name: _____ Relationship to Child: _____

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INFORMED CONSENT FORM

I, _____, the parent/legal guardian of _____, hereby request and consent to Emerge Speech & Language LLC providing treatment and care as prescribed by a physician and/or recommended by a Speech language pathologist.

For minor children, I acknowledge and agree that a parent or legal guardian must be present (in the home for home-based visits or in the waiting area of the office for clinic-based visits) during each treatment session.

I have carefully read and fully understand this Informed Consent Form and have had the opportunity to discuss it with the treating therapist.

I consent and authorize Emerge Speech & Language LLC to administer treatment under the direction and supervision of a certified Speech-Language Pathologist.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name: _____

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MEDICAL RECORDS RELEASE FORM

Child's name: _____ DOB: _____

I _____ hereby authorize Emerge Speech & Language LLC to release, use, discuss, and/or disclose Speech language pathology and relevant health and medical information to the entities listed below.

NAME/FACILITY	ADDRESS	PHONE	EMAIL

I understand that the protected health information will be shared for relevant health/medical, legal, and/or educational reasons. Information may include speech/language assessments or evaluation results, treatment plans, progress notes, medical records, and/or academic information.

I understand that I can revoke my authorization at any time by providing a written request to the office.

I understand that this release form provides additional consent beyond what is outlined in the HIPAA Privacy Notice form, which I have read and reviewed.

Your Signature: _____ Date: _____

Printed Name: _____

Child's Name: _____ Relationship to Child: _____

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PHOTO RELEASE FORM

I give permission to Emerge Speech & Language, LLC to take and use (check all that apply).

___ **Audio recordings**

- ___ Limited portions of initial evaluation, so that footage may be reviewed for accuracy when scoring assessments of speech sound production
- ___ On Emerge Speech & Language's website
- ___ On Social media, including Instagram and/or Facebook

___ **Video recordings**

- ___ On Emerge Speech & Language's website
- ___ On Social media, including Instagram and/or Facebook

___ **Photographic Images**

- ___ On Emerge Speech & Language's website
- ___ On Social media, including Instagram and/or Facebook

___ **I do NOT give permission for any of the above.**

Your Signature: _____ Date: _____

Printed Name: _____

Child's Name: _____ Relationship to Child: _____

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TELETHERAPY CONSENT FORM

Teletherapy is the practice of delivering clinical health care services via technology-assisted media or other electronic means between a practitioner and a client who are located in two different locations.

1. I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
2. I understand that there are risks, benefits, and consequences associated with teletherapy, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3. I understand that there will be no recording of any of the online sessions by either party unless agreed to before the session. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
4. I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to teletherapy unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others).
5. I understand that during the course of treatment, it may be determined that teletherapy services are not appropriate and in-person speech therapy is required.
6. I understand that during a teletherapy session, we could encounter technical difficulties resulting in service interruptions. Reasonable efforts will be made to reconnect or reschedule the session if necessary.

By signing below, I acknowledge that I have received, read, and understood the above details and policies regarding teletherapy provided by Emerge Speech & Language LLC.

Your Signature: _____ Date: _____

Printed Name: _____

Child's Name: _____ Relationship to Child: _____