Speech for the Stars, LLC
Leah Doherty, M.S., CCC-SLP
Phone: 732-299-7144
Email: leahdohertyslp@gmail.com
www.speechforthestarsllc.com

OFFICE USE ONLY	
ID	
DATE	
OTHER	

Speech for the Stars, LLC

Intake packet

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 AT YOUR CHILD'S FIRST THERAPY SESSION.

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

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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 1 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?	RELATION TO CHILD	RELATED DIAGNOSIS/DISORDER

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(e.g., ADHD, autism)		

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 _____

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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	
To the best of your knowledge, 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?	

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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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CONSENT FOR RELEASE OF INFORMATION

As the parent/guardian of _____, I hereby consent for the release of
FULL NAME OF CHILD

information _____ (TO) and/or _____ (FROM) the speech-language pathologist of **Speech for the Stars, LLC** and its affiliates for the coordination of services for my child. Specifically, I consent for the following persons and/or entities to consult via all means of communication, regarding my child's status in the areas of:

____ COMMUNICATION

____ BEHAVIOR

____ HEALTH/MEDICAL

____ ACADEMICS

NAME(S) OF PERSONS/ENTITIES:

_____

_____

_____

_____

By signing below, I understand that this consent will remain effective for one year from the date of signing and that I may withdraw this consent at any time.

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

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NOTICE OF PRIVACY PRACTICES

Your Privacy Rights

Effective date **August 2019**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU/YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. A government rule requires that you receive a copy of this privacy notice. This rule is called the Health Insurance Portability and Accountability Act, or HIPAA for short. We will ask you to sign a paper saying that you have been given this notice. Read this notice at any time to see how your health information can be used and who can see it.

Speech for the Stars, LLC is required by law to keep your health information safe. This information may include:

- Notes from your doctor, teacher, or other health care provider
- Your medical history
- Your test results
- Treatment notes
- Insurance information

How your health information may be used or shared. We may use or share your health information without your permission for:

- **Treatment**. We may share information with doctors and other health care providers who care for you. For example, if your doctor orders speech therapy, we will share the results of our treatment with that doctor.
- **Health Care Operations**. We may use and share your health information to run the clinic and make sure all patients receive good care. For example, we may use your health information to:
  - see how well our services are working
  - see how well our staff is doing
  - see how we compare to other clinics
  - make our services better
  - help others study health care services

Your Health Information May Also Be Used or Shared Without Your Permission for:

- **Abuse and Neglect**. We may share your health information with government agencies when there is evidence of abuse, neglect, or domestic violence.
- **Appointment Reminders**. We will use your information to remind you of upcoming appointments. Reminders may be sent in the mail, by email, by text, by phone call, or voicemail message. If you do not wish to get reminders, please tell your speech-language pathologist.
- **As Required by Law**. We will share your information when we are told to do so by federal, state, or local law. We will also share information if we are asked by the police or courts.
- **Threats to Health and Safety**. Your health information may be shared if it is believed that it will prevent a threat to your health and safety or the health and safety of others.

When Your Permission is needed to Use or Share your Health Information

You must give us permission to use or share your health information for any situation that is not listed in this notice. You will be asked to sign a form, called an authorization, to allow us to use or share your information. You are allowed to take back this authorization, called revoking authorization, at any time. We will not be able to get the information back that we shared with your permission.

Your Privacy Rights. You have the right to:

- **Ask us to not share your information.** You can ask us to not use or share your information for treatment, payment, or health care operations. You can also ask us not to share information with people involved in your care, like family members or friends. You must ask for limits in writing. We must share information when required by law. We do not have to agree to what you ask.
- **Ask us to contact you privately.** You can ask us to only contact you in a certain way or at a certain place. For example, you may want us to call but not email. Or you may want us to call at work but not at home. You must ask us in writing. We will do all we can to do as you ask.
- **Look at and copy your health information.** You have the right to see your health information and get a copy of that information. You have a right to see treatment, medical, and billing information. You may not be able to see or copy information put together for a court case, certain lab results, and copyrighted materials, such as test protocols.
- **Ask for changes to your health information.** You can ask us to change information that you think is wrong. You can also ask that we add information that is missing. You must ask us in writing and give us a reason for the change. We do not have to make the change.
- **Get a report of how and when your information was used or shared.** You can ask us to tell you when and with whom your information was shared. There are some rules about this:
  - You need to ask us in writing.
  - You must tell us the dates you are asking about and if you want a paper or electronic copy.
- **Get a paper copy of this privacy notice.** You can get a paper copy of this notice at any time. You can get a copy even if you have already signed the form saying you have seen this notice.
- **File complaints.** You can file a complaint with us or with the government if you think that:
  - Your information was used or shared in a way that is not allowed.
  - You were not allowed to look at or copy your information.
  - Any of your rights were denied.

Who is Covered by This Notice

The people that must follow the rules in this notice are:

- All speech-language pathologists, assistants, and audiologists working at this clinic.
- Anyone who is allowed to add health information to your file, including students and other staff.
- Any volunteers who may help you while you are in this clinic.

Changes to the Information in This Notice
We may change this notice at any time. Changes may apply to information we already have in your file and any new information. Copies of the new notice will be available from our staff. The notice will have a date on the front page to tell you when it went into effect.

Contacts
If you have any questions about this notice or your privacy rights, please ask your speech-language pathologist.

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Acknowledgement That You Have Received Our Privacy Notice

Our clinic is required by law to keep your health information safe. This information may include:

- Notes from your doctor, teacher, or other health care provider
- Your medical history
- Your test results
- Treatment notes
- Insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information may be used and shared. It also tells you how to access and request changes to your information.

By signing this page, you agree that you have been given a copy of our privacy notice.

____ ________________________
PARENT/GUARDIAN SIGNATURE DATE

____ ________________________
CLIENT/CHILD NAME DATE OF BIRTH
~~~~~~

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PAYMENT POLICY

We are committed to helping your child reach the goals of his/her individualized treatment plan. Our services, including travel and specialized therapy materials, depend on the timely payment of accounts. Please read and sign this policy to indicate your understanding and agreement.

FULL PAYMENT IS DUE ON EACH DATE OF SERVICE, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE, PAYMENT CAN BE MADE VIA CASH, CHECK, OR VENMO ON THE DATE OF SERVICE. CREDIT CARD PAYMENT IS NOT AVAILABLE, AT THIS TIME. EACH THERAPY SESSION IS 45-MINUTES LONG, APPROXIMATELY 35-40 MINUTES OF DIRECT THERAPY TIME AND 5-10 MINUTES OF PARENT EDUCATION/CONSULTATION AND COMPLETING PROGRESS NOTES. THE REGULAR SPEECH-LANGUAGE THERAPY SESSION RATE IS CHARGED AT $110.00 PER SESSION. FEEDING THERAPY SESSIONS ARE CHARGED AT $140.00 PER SESSION TO ACCOUNT FOR FOOD COST AND THERAPIST SHOPPING/PREP TIME. THIS RATE IS SUBJECT TO CHANGE AT THE OFFICE DISCRETION WITH PRIOR NOTICE.

CANCELLATIONS: All canceled appointments will be rescheduled if possible. Missed appointments jeopardize the therapist's travel time, planning time, and report writing. Please be considerate of your therapist's time by canceling appointments within a reasonable amount of time. Cancelations should be made by the evening before your scheduled appointment. In the event of sudden child/parent illness, all cancelations must be made by 7 AM on the day of your appointment. Please review the policy below:

Canceled by you **with prior notice**: rescheduled session at a time that the therapist is available.
Canceled by you **with no prior notice** ("no show"): session will be charged at 100% of the normal session rate.

- If the child is not home or absent from school or other facility on the day of a scheduled session, and you have not given prior notice of the absence directly to the therapist, the session will be charged at 100% of the normal session rate. This also includes late cancelations.

Canceled **by the therapist**: rescheduled session at a time that the therapist is available.

If you or your child arrives late to an appointment, the session will end at the regular session time and you will be responsible for the full session fee.

OTHER BILLED SERVICES: Speech for the Stars, LLC offers additional services, including screening, observation, evaluation, reports, peer to peer interaction with insurance companies, and attending parent-teacher conferences. These services will be billed in addition to the therapy session charges. Sessions that are located out of a ten mile radius to the clinician's location will be charged at an additional rate for travel time. Please speak to your therapist in regards to additional rates.

PAST DUE ACCOUNTS: In the event that an account becomes past due, your child's speech-language services will cease until payment is received.

METHOD OF PAYMENT:
We accept many forms of payment:
Cash: Exact change required
Personal Check: Make payable to Speech for the Stars, LLC. Returned check fee: $25.
Venmo: You may send payment directly to @LEAH-DOHERTY

Please indicate your understanding and agreement to this payment policy by signing below.

_____

Parent/Guardian signature

Continue to next page.