3119 Lithia Pinecrest Rd • Valrico, Fl 33596

Office Telephone: 813-662-1106 - Office Fax 813-661-7661

Client Demographic Information

Client Name (Last, First) _____

Social Security # _____ DOB _____ Gender M___ F___

Home Address _____

City, State & Zip Code _____

Parent/Guardian of Client _____

Relationship to Client _____ Email _____

Mailing Address (if different than client) _____

City, State, & Zip Code _____

Contact Numbers: Cell _____ Home/Work _____

Emergency Contact Name _____

Telephone Number _____

A parent or guardian is required to remain in the waiting area or in their car while speech therapy is in session. In the event a parent should have to leave (upon office/therapist approval), the emergency contact will be notified if the parent does not answer.

Primary Care Physician Information

Name of Primary Care Physician: _____

Primary Care Physicians Phone Number: _____

and address: _____

_____

Payment and Insurance Information

Will your child be self-pay? Yes _____ No_____

*If YES, the Self Pay terms and agreements will be discussed.

Does your Child have Insurance? Yes _____ No _____

Insurance Information

Primary Insurance _____

Policy Number _____

Group Number _____ Individual Number _____

Policy Holders Name _____ Relationship to client _____

*If you have a secondary insurance policy, please complete the following information. If the client does not have a secondary policy, please proceed to page 3.

Secondary Insurance _____

Telephone Number _____

Policy Number _____

Group Number _____ Individual Number _____

Policy Holders Name _____ Relationship to client _____

Pregnancy/Childbirth History

Was prenatal care given to mother and child during pregnancy? Yes_____ No_____
Were there any complications during pregnancy? Yes_____ No_____
If you answered yes, please explain: _____
_____
_____
_____

Length (term of pregnancy) _____
Was the child delivered by Vaginal birth _____ or C-Section _____
Following the delivery did the child spend time in the NICU? Yes _____ No _____
If you answered yes, please explain why the child spent time in the NICU _____
_____
_____
_____

Developmental History

Please give the approximate age that your child performed the events below. If an event has not occurred, you may leave it blank.

Milestones:
Smiled _____
Followed objects with their eyes _____
Ate solid foods _____
Held/Picked up objects _____
Clapped hands _____
Rolled over _____
Held bottle _____
Crawled _____
Stood alone _____
Walked _____
Feed self _____
Dressed self _____
Potty trained _____

Medication's Prescribed

Is your child currently on any medications? If Yes, please indicate what medications your child has been prescribed:

_____
_____
_____

Speech Developmental History

Please give the approximate age that your child performed the events below. If an event has not occurred, you may leave it blank.

First word/words spoken _____
Does child say simple words (dog, car, tree, etc.) _____
Combine words (me go, daddy shoe, etc.) _____
Simple questions (Where's doggie? etc.) _____
Engages in conversation _____
Does child have difficulty walking, running, or participating in other activities which require small or large muscle coordination? If Yes, please describe. _____
_____
Does your child have any feeding problems (swallowing, sucking, drooling, chewing)? If Yes, please describe.
_____
_____
Does your child respond to sound? If Yes, please describe how. _____
_____

Is there a family history of speech/language difficulties? If Yes, please explain. _____
_____
_____

Vision & Hearing History

Has your child received a vision evaluation? Yes _____ No_____ Age_____
If your child has had a vision evaluation did the child pass or fail the test? _____
Do you feel your child has vision problems? If Yes, please explain. _____
_____

Does your child suffer from ear infections? If Yes, how many in a year? _____
Has your child received a hearing screening? Yes _____ No_____ Age_____
If your child has had a hearing screening did the child pass or fail the test? _____
Do you feel your child has hearing problems? If Yes, please explain. _____
_____

Child's Medical History

Please provide the approximate age at which your child has suffered the following illness/condition.

Allergies _____	Asthma _____	Chicken Pox _____
Colds _____	Convulsions _____	Croup _____
Dizziness _____	Draining Ear _____	Ear Infections _____
Encephalitis _____	German Measles _____	Headaches _____
High Fever _____	Influenza _____	Mastoiditis _____
Measles _____	Meningitis _____	Mumps _____
Pneumonia _____	Seizures _____	Sinusitis _____
Tinnitus _____	Tonsillitis _____	Other _____

Describe any major accidents or hospitalizations: _____
_____
Has the child had any surgeries? If Yes, please explain. _____
_____
Is the child currently on any medications? If Yes, please list the names of each medication.
_____
_____

Describe the child's speech/language problem. _____
_____

How does the child communicate? _____
_____

When was the problem first noticed? _____
Has there been any improvement? _____

Has the child been referred by a physician for speech therapy? _____
Has the child been seen/evaluated for speech therapy? If Yes, who was the speech pathologist and how long ago was the child seen? _____
_____

Permission for Speech Therapy

I give my permission for my child to be evaluated/treated for speech therapy. I also give Kid's Therapy Unlimited, Inc. permission to access my child's medical records and permanent client records (if available).

_____
Printed name of parent or guardian

_____ _____
Signature of parent of guardian Date

Availability

If your child needs speech therapy, please tell us the times you are available for speech sessions.
Example: Tuesday, 9am-12:00pm
Monday _____
Tuesday _____
Wednesday _____
Thursday _____
Friday _____

Guarantee of Payment

I give authorization to Kid's Therapy Unlimited, Inc. to bill my insurance company or credit card company, (credit card authorization form on file) for speech therapy services rendered. I agree that if my insurance company refuses or denies any claim made, I am responsible for the payment of the service(s).

I also understand I am responsible for any co-payment that is required by my insurance at the time of therapy services.

_____
Printed name of parent or guardian

_____
Signature of parent of guardian

_____
Date

Cancellation/No Show Policy

For Speech Therapy

Cancellations

We understand that emergencies happen, and you may have no choice to miss an appointment. If you are unable to notify us before your appointment time, we ask that you notify us as soon as possible. In the event an appointment is canceled a make up session maybe required (per insurance guidelines).

No Show

If you are unable to keep your appointment time, we ask that you call the office to cancel. If you do not call the office this will be considered a "No Show". If a client has 3 appointments that are considered no shows in a 6-month period, we reserve the right to dismiss the client from speech therapy with Kid's Therapy Unlimited, Inc.

Scheduled Appointments

Delays can occur that prevent you from being at your scheduled appointment on time. You must call the office if you are going to be late. We will notify the therapist and let you know if the therapist is able to see the client. Therapists keep a running client schedule. If you are late to your appointment this could prevent the therapist from seeing other clients on time and your appointment may need to be re-scheduled.

By signing below, you understand and agree to the policies written above.

_____ _____

Parent or Guardian Printed Name Date

_____

Parent or Guardian Signature