Teach beyond Speech

WELCOME

Thank you for choosing Teach Beyond Speech Therapy, LLC to help meet your child's communication and educational needs. I realize there are many options to choose from, but I assure you that my background in teaching, personal experiences, expertise in speech and language therapy and knowledge in exceptional student education, will help your child reach his or her maximum potential. I sincerely appreciate this opportunity, and I look forward to working with you and your child.

The attached New Client Paperwork packet includes important information about my practice. Please take time to fill out as much information as possible regarding your child's developmental history, as this information can be vital to the direction of the therapy plan. I understand that these forms can be time consuming; however, it is important that I have as much information as possible prior to your first visit so that I may provide the best possible service for your child. If your child has any recent evaluations completed by other health professionals (psychologist, IEP, etc.), please bring copies of these with you or may email them to me in advance.

Completed form packets may be e-mailed to elisa@teachbeyondspeech.com or mailed to 11021 S.W. 16th Manor, Davie, Florida 33324. Please feel free to call me or e-mail me with any questions or concerns regarding this packet.

Sincerely,

Elisa Cartagena, M.S. CCC-SLP
Owner and Lead Therapist

Teach beyond Speech

IDENTIFYING INFORMATION:

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

E-Mail: _____

Phone 1: _____ Phone 2: _____

Parent/Guardian Names: _____

Mother's Occupation: _____ Father's Occupation: _____

Child lives with both parents? Yes _ No _ Primary language spoken in home: _____

Others living in the home: (names, ages, and relationship) _____

_____

REFERAL SOURCE:

How did you hear about us? _____

Pediatrician: _____ Phone: _____

Reason for referral: _____

Previous evaluations (list): _____

Therapy to date (list): _____

Describe present problem: _____

_____

Who noted present problem? _____ When: _____

What is your child's reaction to the problem (if any)? _____

_____

How does the family react to the problem? _____

Has there been any significant change in last six months? _____

If so, what? _____

How well is your child understood by others? _____

Describe what it is like to have a conversation with your child: _____

_____

_____

PRENATAL/BIRTH HISTORY:

Full Term: Yes ___ No ___ If no, how many weeks? _____

Illnesses or accidents during pregnancy: _____

Use of alcohol, tobacco or medications during pregnancy: _____

Birth weight:_____ Delivery: _Vaginal _Cesarean _Breech

Other unusual conditions that may have affected pregnancy or birth? _____

_____

MEDICAL HISTORY:

Please check if your child has had any of the following (and if so, at what age):

___ Allergies ___ Asthma ___ Chicken Pox ___Chronic Cold

___ Chronic Ear Infections ___Ear Tubes ___ Frequent Cough___ Hearing Loss

___ Heart trouble ___ Measles ___ Mumps ___Meningitis

___ Pneumonia ___ Sinusitus ___ Thyroid ___Tonsilitis

___ Other

Explain any checked items here: _____

List any current medications: _____

Are immunizations current? _____Current general health: _____

_____

Has your child ever had an ear infection? (If so, how many?) _____

How have the infections been treated: _____

Ear tubes? (What age/how long were they in place?)_____

Allergies? _____

Any operations, accidents, or hospitalizations?_____

_____

Vision problems? _____ Treatment: _____

Dental problems? _____Treatment: _____

Any other additional information: _____

_____

_____

DEVELOPMENTAL HISTORY

In your opinion, how does your child's overall development compare to that of other children his/her age _____ *Give the approximate age at which your child:*

Sat unsupported: _____ Crawled:_____ Stood: _____

Walked alone: _____ Fed Self: _____ Dressed Self: _____

Was toilet trained: _____ Tied Shoes: _____

Is the child left or right handed? ____

Able to use? (Y/N) open cup____ spoon ____ straw ____ blow bubbles ____

Difficulty? (Y/N) Swallowing: ___ Chewing: ___ Drinking: ___ Blowing: ___ Drooling: ___

Favorite Foods: _____

Food Aversions (if any): _____

Eating and sleeping patterns: _____

Eat and sleep well? _____Cry appropriately? _____Laugh? _____Smile? _____

Make wants/needs known? ____ How? _____

Does your child show unusual behavior (explain)? _____

Does your child respond to: Light? _____Sound? ____People? ____

Does your child: Play with others? _____Who? _____

How would you characterize your child's interaction with:

Siblings: _____ Parents: _____

Peers: _____ Other adults: _____

Does your child's attention span seem appropriate for his/her age? _____

Is your child active, hyperactive, or lethargic? _____

LANGUAGE DEVELOPMENT:

Age when your child:

Spoke first word: _____Combined words: _____Spoke in sentences: _____

What was your child's first word(s)? _____

First sentence? _____

Which sounds (if any) are incorrect? _____

How many words can your child say? _____

(list if fewer than ten) _____

_____

How long are your child's sentences? _____

Does your child have any difficulty understanding you? (describe) _____

_____

Does your child have difficulty following directions? (describe) _____

Any speech or hearing problems in the immediate or extended family (please explain):

_____

Has your child attended day care?_____

Number of regular playmates:_____

Favorite activities:_____

Howdoes your child handle frustration: _____

Conflict: _____

Regular responsibilities: _____

What motivates your child the most? _____

What discipline works best? _____

EDUCATIONAL BACKGROUND:

Present school: _____ Grade: _____

Teacher: _____

Other professionals working with your child: _____

How does your child's teacher describe his/her performance? _____

_____

Has the teacher expressed concerns? If so, what?

_____

_____

If your child has been enrolled in Special Education services, has an Individualized Educpation Plan (IEP) been developed? (If so, please attach a copy): _____

_____

Please provide any additional information you believe might help me better understand your child in this process:

_____

_____

_____

OTHER:

What do you hope to have happen as a result of this evaluation? _____

_____

Does the report need to be sent to specific agencies? ____Where? _____

Anything else you would like us to know?

_____

_____

_____

CONTACT INFORMATION:

At times we may need to contact you for appointment reminders or other concerns. Please complete only the items below that you authorize as a method of contact.

Home address: _____

_____

Home Phone: _____ Ok to leave message? __yes __no
Mother's Cell Phone:_____ Ok to leave message? __yes __no
Father's Cell Phone: _____ Ok to leave message? __yes __no
Mother's Work: _____ Ok to leave message? __yes __no
Father's Work: _____ Ok to leave message? __yes __no

Mother's email: _____ Ok to leave message? __yes __no
Father's email: _____ Ok to leave message? __yes __no

*Please note: Home address, and at least 1 phone number and email address are required.

POLICIES AND PROCEDURES

Appointments

- Please arrive at your appointment on time.
- If you must cancel an appointment that you have scheduled, please call immediately. Except under emergency circumstances, all appointments cancelled with less than 24 hours notice will be subject to a $30 service fee.
- If no notice is provided, the full session fee will apply.
- In the event that you arrive late for your appointment, we will do our best to see you, however, the appointment may be shortened due to time constraints; however, the full session fee still applies.
- All sessions end 5 minutes early to allow for parent consultation.

Confidentiality

Your privacy is very important to us. We strongly recommend that you review the Notice of Privacy Policy for important details regarding policies for maintaining confidentiality. In particular, you should be aware that we will only contact you via means that you have specifically authorized in your new client paperwork. If you would like us to exchange information with persons other than yourself, an Authorization for Release of Information form must be completed. This form can be downloaded from the client forms section of my website.

Fees

We will always inform you of the charges prior to providing any type of clinical service. A schedule of fees can be obtained from my office or website at any time. A full list of fees can be found at www.teachbeyondspeech.com/fees. Fees apply to various types of services including direct client contact (clinic based or offsite), phone consultations, travel, and consultation with other professionals.

Health Insurance

We currently do not participate with insurance companies. We will be happy to provide you with the necessary paperwork to assist you in seeking reimbursement for out-of-network provider services. Please also be advised that many health insurance plans have limited coverage for speech-language pathology services. We recommend that you contact your insurance company to discuss the limits of your coverage.

Health Policy

Help and cooperation is required in order to maintain a healthy environment. A child must be temperature-free for 24 hours before returning to therapy. If your child has vomiting and/or diarrhea, he/she should not return to therapy until 24 hours have passed since the last episode of the same.

Children will not be seen if any of the following is present:

- Too ill or uncomfortable to function in the therapy setting.
- Continual runny nose.
- Thick or discolored nasal discharge.
- Excessive sneezing or coughing and mucus-producing cough.
- An elevated temperature.

NOTICE OF PRIVACY POLICIES

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.

Our Legal Duties

State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. Teach Beyond Speech, LLC is required to abide these policies until replaced or revised. Teach Beyond Speech, LLC have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place. The contents of material disclosed to us in an evaluation, intake form, or counseling sessions are considered private information by law. Teach Beyond Speech, LLC respect the privacy of the information that you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information

Information about you may be used by the personnel associated with Teach Beyond Speech, LLC for diagnosis, treatment planning, treatment, and continuity of care. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is the policy of Teach Beyond Speech, LLC not to release any information about a client without a signed release of information except in certain emergencies or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Public Safety

Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

Abuse

If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

Prenatal Exposure to Controlled Substances

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Professional Misconduct

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meetingis being held regarding the health care professional's actions, related records my be released in order to substantiate disciplinary concerns.

Judicial or Administrative Proceedings

Health care professionals are required to release records of clients when a court order has been placed. In the event of a court order, the minimally acceptable amount of information will be revealed. Additionally, if a client files a complaint or lawsuit against anyone affiliated with Teach Beyond Speech, LLC; relevant information regarding the client may be disclosed for the purpose of formulating an appropriate defense.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records unless it is determined that access would have a detrimental effect on the therapeutic relationship or on the client's physical safety or psychological well-being.

Other Provisions

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases, the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Communications with the client outside the clinic setting will only occur as authorized by the client. When it is necessary to contact the client via telephone, messages will not be left on voicemails (or with persons other tan the client or client's legal guardian) unless Teach Beyond Speech, LLC has received written authorization to do so.

Your Rights

- You have the right to request to review or receive your medical files. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is $.25 per page, plus postage.
- You have the right to cancel a release of information by providing Teach Beyond Speech, LLC a written notice.
- You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them.
- You have the right to request that information about you be communicated by other means or to another location.
- You have the right to disagree with the medical records in our files and request a change to this information. Although we may deny the change request, you have the right to make a statement of disagreement.
- You have the right to know what information in your record has been provided to whom.
- You have the right to request a copy of this notice.

Complaints

If you have any complaints or questions regarding these procedures, please contact me. I will get back to you in a timely manner. If you believe your privacy rights have been violated, complaints should also be directed to Teach Beyond Speech, LLC. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201. There will be no retaliation for filing a complaint with either Teach Beyond Speech, LLC or the Office of Civil Rights.

Patient's Rights

As a recipient of services at Teach Beyond Speech, LLC, we would like to inform you of your rights. Below is a description of each of your rights. If at any time you feel your rights have been violated, please contact Teach Beyond Speech, LLC and ask to speak with me.

- You have the right to refuse or terminate services at any time for any reason. Your participation in services is voluntary.
- You have the right to submit complaints or suggestions at any time. Teach Beyond Speech, LLC will fully investigate any complaints and seriously consider any suggestions you have for improving the services we provide.
- You have the right to information regarding the cost of services. Teach Beyond Speech, LLC will always inform you of charges before we provide a service. A schedule of fees can also be obtained from our office at any time.
- You have the right to privacy. Please see our Notice of Privacy Policy for information regarding certain limits to confidentiality and how your protected health information will be used.
- You have the right to know under what conditions we will terminate our services. Please refer to Teach Beyond Speech, LLC Policies and Procedures document for this information.
- You have the right to be informed of any changes in our policies. You will always be notified in the event that we change a policy that is relevant to the services we provide you.

CONSENT FORM

***This form must be completed before services can be initiated. If the client is under the age of 18 years, the form must be signed by all legal guardians.**

Consent for Treatment

I hereby attest that I have voluntarily applied for and entered into treatment, or give my consent for the minor or person under my legal guardianship, at Teach Beyond Speech, LLC. I understand that I may terminate these services at any time.

Receipt of Policies and Procedures

I hereby attest that I have received a copy of Teach Beyond Speech, LLC's *Policies and Procedures,* including payment policies, and have read, understand and consent to be bound by its content.

Receipt of Patient's Rights

I hereby attest that I have received a copy of the *Patient Rights* notice, have read, and understand its content.

Receipt of Privacy Policy and Consent for Disclosure of Health Information

I have been provided a copy of Teach Beyond Speech, LLC's *Notice of Privacy Policies* detailing how my medical record may be used and disclosed under Federal and State law. I understand that as a part of Teach Beyond Speech, LLC's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity (i.e., insurance, emergency, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax and e-mail only to appropriate parties. I fully understand and accept the terms of this Consent and acknowledge the receipt of the Privacy Notice. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I understand that by refusing to sign this consent or revoking this consent, Teach Beyond Speech, LLC may refuse to treat me. I further understand that Teach Beyond Speech, LLC reserves the right to change its privacy policies and will provide me with a copy of any revised notice.

Photocopy Authorization

I permit a photocopy of this consent form as if it were an original executed consent.

Name of Patient (Printed): _____

By signing below, you are attesting to the accuracy of the above statements including all consents and authorizations implied therein. A copy of this agreement is available upon request.

_____ _____

Legal Guardian Signature Date

Signatures in writing must be obtained on or before day of evaluation appointment.