Speech Therapy Plus, pllc.
1421 FM 359, Suite H
Richmond, TX 77406
(281) 232-1900
Team@Speechtherapyplus.com

Patient Information:

Last Name: First Name: Middle Initial:

Address: Apt. #

City: State: Zip Code:

Home Phone: Work Phone:

Cell Phone: Fax:

Email Address:

Patient's Date of Birth: Parent SSN: Patient's Sex ◯ M ◯ F

Parent/Guarantor Name:

Primary Insurance Information:

Insurance Company:

Subscriber #: Group #:

Name of Insured: D.O.B. of Insured:

Employer of Insured: Work Phone:

Employer Address:

Work Status (Check one): ◯ Full Time ◯ Part Time ◯ Retired ◯ Unemployed

Secondary Insurance Information:

Insurance Company:

Subscriber #: Group #:

Name of Insured: D.O.B. of Insured:

Employer of Insured: Work Phone:

Address of Employer:

Work Status (Check one): ◯ Full Time ◯ Part Time ◯ Retired ◯ Unemployed

Emergency Contact Information:

Name: Relationship:

Home #: Cell #:

Address:

Who should we thank for referring you to us?

Current Physician / Pediatrician:

Address:

Phone No: Fax:

I authorize Speech Therapy Plus, pllc. to bill my insurance company. I understand that I am financially responsible for charges, whether or not paid for by my insurance. I hereby authorize the release of all information necessary to secure payments of benefits. I authorize the use of this signature on all insurance submissions.

Signature: Date:

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Pediatric and Adolescent Patient Medical History Form

List members of Immediate Family Currently Living in the Home

Name	Age	Relationship	Health Problems

Prenatal/Birth History: (Write on the back if needed)

Were there any complications with the pregnancy? ◯ Yes ◯ No If yes, please explain:

Were there any complications with the delivery: ◯ Yes ◯ No If yes, please explain:

Length of pregnancy ____ months Birth Weight ____ lbs. ____ oz. Length ____ in.

Difficulties following birth:

- Trouble breathing ☐
- Turned yellow (Jaundice) ☐
- Turned blue ☐
- Required oxygen ☐
- Required Incubation ☐
- Trouble sucking ☐
- Intubation ☐
- Length of stay in the hospital

Difficulties during infancy:

- Sucking ☐
- Swallowing ☐
- Colic ☐
- Reflux ☐
- GERD ☐
- Irritable ☐
- Limp ☐
- Rigid ☐
- Difficulty sleeping ☐
- Overactive ☐

Please list any other difficulties following birth or during infancy:

Medical History:

Please indicate if your child has experienced any of the following conditions:

Allergies	☐ Yes	Explain
Attention Deficit Disorder	☐ Yes	Explain
Autism	☐ Yes	Explain

Asthma	☐ Yes	Explain
Concussion	☐ Yes	Explain
Epilepsy	☐ Yes	Explain
Frequent Colds	☐ Yes	Explain
High Fevers	☐ Yes	Explain
Intellectual Disability	☐ Yes	Explain
Learning Disability	☐ Yes	Explain
Meningitis	☐ Yes	Explain
Muscular Disease	☐ Yes	Explain
Reflux	☐ Yes	Explain
Respiratory Infections	☐ Yes	Explain
Seizures (last one was?)	☐ Yes	Explain
Tonsillitis	☐ Yes	Explain
Traumatic Brain Injury	☐ Yes	Explain
Vision Problems	☐ Yes	Explain

Please list and describe any other important injuries, illnesses, and major operations and when they happened:

Has your child ever been under the care of any other specialists? If yes, please list the doctor and state the dates treated:

☐ Neurologist:

☐ Psychologist

☐ Ear, Nose and Throat:

☐ Developmental Pediatrician:

☐ Other:

Would you like a copy of your child's report sent to them in addition to the pediatrician? ○ Yes ○ No

If not, please explain:

Are your child's immunizations up to date? ○ Yes ○ No

Please list all medications your child is currently taking:

Is your child allergic to any medications? ○ Yes ○ No

If yes, please list medications and their reactions:

Does your child have any food allergies? ◯ Yes ◯ No If yes, please list all allergies:

Does your child currently have any medical problems? ◯ Yes ◯ No If yes, please explain:

How many ear infections does your child have per year?

Has your child had ear tubes? ◯ Yes When ◯ No

Has your child's hearing ever been tested? ◯ Yes ◯ No If yes, what were the results of that testing:

Does he/she wear a hearing aid? ◯ Yes ◯ No If yes, for how long?

Have your child's eyes been examined? ◯ Yes ◯ No If Yes, when & what were the results of that examination:

Is your child currently wearing glasses? ◯ Yes ◯ No Please list any major illnesses, injuries or operations on the child. Include information such as type, age, treatment, complications and any continuing effects associated with these events:

Family History: If patient or family member has or has had any of the following problems, mark as indicated below and explain in the space provided:

P-Patient M-Mother F-Father GM-Grandmother GF-Grandfather A-Aunt U-Uncle

- chronic illness:
- allergies:
- speech problem
- hearing problem:
- swallowing problems:
- asthma/lung problems:
- respiratory infections:
- tuberculosis:
- immunity problems/HIV:
- heart condition:
- cerebral palsy:
- intellectual disability:
- down syndrome:
- autism:
- cancer:
- seizures:
- mental illness:
- other:

Developmental History:

Are there or have there been any developmental issues with the child? ◯ Yes ◯ No

Did your child's speech/language seem to develop normally? ◯ Yes ◯ No

At what age was a speech problem first noticed?

Do you consider this problem: ◯ Severe ◯ Moderate ◯ Mild

Do family members understand your child's speech? ◯ Always ◯ Sometimes ◯ Very Little

Do people not familiar with your child understand their speech? ◯ Always ◯ Sometimes ◯ Very Little

Does your child stutter or stammer? ◯ Yes ◯ No If yes, for how long?

Are there any concerns regarding your child's voice in relation to his/her peers? (for example: very loud, hoarse, very soft, nasal?) If yes, please explain:

Receptive and Expressive Language Skills

Please answer "yes" or "no" or "sometimes" to the following questions:

Does your child respond to his/her name? ◯ Yes ◯ No ◯ Sometimes

Will your child get familiar objects when asked? ◯ Yes ◯ No ◯ Sometimes

Does your child follow simple directions? ◯ Yes ◯ No ◯ Sometimes

Will your child point to pictures as you name them? ◯ Yes ◯ No ◯ Sometimes

Does your child name pictures? ◯ Yes ◯ No ◯ Sometimes

Does your child ask questions? ◯ Yes ◯ No ◯ Sometimes (Please give examples)

Does your child repeat or "echo" others' expressions? ◯ Yes ◯ No ◯ Sometimes

Does your child repeat questions or parts of questions rather than answering them? ◯ Yes ◯ No ◯ Sometimes

Does your child excessively recite/repeat phrases from movies, songs or television programs?
◯ Yes ◯ No ◯ Sometimes

Does your child fixate on the same subject day after day? ◯ Yes ◯ No
Explain

Has your child said a word a few times, then never used it again? ◯ Yes ◯ No
IF "yes", when? What words?

Did language development seem to just stop? ◯ Yes ◯ No ◯ Sometimes
IF "yes", when?

How does your child indicate his/her needs/wants to you?

How does your child indicate he/she does **NOT** want something or does not want to do something?

Motor Milestones

Please indicate the age or approximate age at which the following occurred:

Cooing _____ Babbling _____ Crawled _____ Sat alone _____ Walked unaided _____

Fed self _____ First words _____ Dressed self _____ Toilet trained _____

Expressive Vocabulary of approximately 50 words: _____

Two-word combinations _____ (Examples: more milk, me do, me down)

Short Sentences _____ (Examples: Me want cookie. Me do it.)

Does your child have any motor or coordination difficulties? (i.e., throwing/catching a ball, riding a bike, jumping, handwriting)? ◯ Yes ◯ No If yes, please list and describe: _____

Does your child walk or run on "tippy toes"? ◯ Yes ◯ No If yes, how often:
◯ Rarely ◯ Occansionally ◯ Frequently ◯ Always

What hand does your child prefer to use for: Writing: ◯ R ◯ L Throwing a ball: ◯ R ◯ L Eating: ◯ R ◯ L

Behavioral Information

General

Is withdrawn: ◯ Yes ◯ No ◯ Sometimes

Rocks back and forth? ◯ Yes ◯ No ◯ Sometimes

Covers ears with hands? ◯ Yes ◯ No ◯ Sometimes

Has limited eye contact? ◯ Yes ◯ No ◯ Sometimes

Has difficulty with change/transitions? ◯ Yes ◯ No ◯ Sometimes

How does he/she get along at home? _____

How does he/she get along at school/daycare? _____

How does he/she get along with other children? _____

What is his/her attitude toward school/daycare? _____

Difficulty sitting still? _____

Difficulty paying attention? _____

Other behavior problems? _____

Describe the child's strengths and/ or special interests: _____

Other comments: _____

Play

Prefers to play alone? ◯ Yes ◯ No ◯ Sometimes

Plays poorly with other children or does not interact with others? ◯ Yes ◯ No ◯ Sometimes

Frequently lines items in a row? ◯ Yes ◯ No ◯ Sometimes

Holds (clutches) items for extended periods of time? ◯ Yes ◯ No ◯ Sometimes

Frequently counts (objects, items, actions etc.) ◯ Yes ◯ No ◯ Sometimes

Has unusual interest (strips of paper, electrical cords etc.)? ◯ Yes ◯ No ◯ Sometimes

Other comments

Conduct

Displays temper tantrums? ◯ Yes ◯ No ◯ Sometimes

Consistently has a catastrophic reaction when told "no"? ◯ Yes ◯ No ◯ Sometimes

Discipline is ineffective? ◯ Yes ◯ No ◯ Sometimes

Is overly active? ◯ Yes ◯ No ◯ Sometimes

Has a short attention span? ◯ Yes ◯ No ◯ Sometimes

Is aggressive towards self? ◯ Yes ◯ No ◯ Sometimes

Is aggressive towards others? ◯ Yes ◯ No ◯ Sometimes

Is destructive with objects? ◯ Yes ◯ No ◯ Sometimes

Other comments

Are you concerned about your child's feeding / swallowing skills? ◯ Yes ◯ No

If yes, please explain:

Does your child stuff food in his/her mouth? ◯ Yes ◯ No

Is your child a pick eater? ◯ Yes ◯ No

If yes, please explain:

Home Information: Does the child live in the home with both parents? ◯ Yes ◯ No

If no, who does the child live with?

Is the child adopted? ◯ Yes ◯ No

If yes, how old were they?

What is the primary language spoken in the home?

If there is more than one language spoken, please list other languages spoken:

School Information: Is the child currently in daycare? ◯ Yes ◯ No

If yes, how many days per week & where

Does your child attend pre-school? ◯ Yes ◯ No

If yes, how many days per week & where

Has your child previously received or currently receiving speech services from ECI? ◯ Yes ◯ No

If yes, at what age and for how long?

If your child is school-aged, what is their current grade level?

What school/district does your child attend?

Does your child receive speech and/or occupational therapy services at his/her school? ◯ Yes ◯ No

How would you describe your child's grades?

Has your child repeated a grade level(s)? ◯ Yes ◯ No If yes, please explain:

Are there any concerns about your child's school experience that you would like to inform me of at this time?

Does your child have specific things that he/she really likes/dislikes?

What are your goals for your child to achieve through speech therapy and/or occupational therapy services?

Is there anything else you would like for me to know about your child (things that upset him, things he will work for, etc.)?

What is the best time for your child to be seen?

Do you prefer a set schedule or flexible schedule?

Re-Eval Update Review
(Initial only when office requests)

Initials	Date
Initials	Date
Initials	Date
Initials	Date

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General Consent of Treatment

I have the legal right to authorize Speech Therapy Plus to provide speech therapy evaluations and treatment services because I am the legal parent/guardian of _____ (patient) and voluntarily give consent to Speech Therapy Plus to provide these services as long as the therapist/patient relationship exists or until I withdraw my consent. _____ (Please initial)

Consent for Consultation Services

I authorize Speech Therapy Plus, PLLC., it's provider(s) and/or other designated office staff to share and consult with other providers (such as PCP, specialist doctors, and other speech therapists) in order to allow and promote the continuity of care for _____ (patient). _____ (Please initial)

Observation Consent

I authorize and give consent for _____ (patient), to receive treatment under the observation of a student either currently enrolled in a Speech Pathology curriculum program or one considering a Speech Pathology career. _____ (Please initial

Consent for Email, Voicemail, and Text Notifications

As a service to our patients, Speech Therapy Plus may need to reach out to you via phone call, text, or email regarding an appointment or other speech therapy related items. At times it may require us to leave a message. The message may include protected health information. By initialing this notice, you consent to receiving such calls/ texts /emails at the phone number or email address you have provided to us. _____ (Please initial)

Email address: _____

Phone number for VOICE MAIL: _____

Phone number to TEXT: _____

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Consent for Release of Information

I authorize Speech Therapy Plus, pllc., it's provider(s), and/or other designated office staff, to release and obtain clinical information for _____ (patient) as it relates to the treatment, authorization for treatment, and for the purposes of insurance reimbursement. I understand this information may be shared with insurance companies, physicians' offices, and/or other required medical/educational offices as it relates to the treatment of this patient. If you have someone that you want your child's information shared with, please list the name(s), relationship to the child, and phone number of that person(s) here: _____

_____

_____ (please initial).

I have read each of the above statements and I understand its contents. I understand I have had an opportunity to ask questions regarding any of these policies before providing consent. Therefore, I hereby agree and consent to all these statements and policies of Speech Therapy Plus. _____
(please initial)

Patient Name: _____ Date of Birth: _____

_____ _____
Name of Parent/Guardian Relationship to Patient

_____ _____
Signature of Parent/Guardian Date

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PRIVACY NOTIFICATION

Speech Therapy Plus is required by law to maintain the privacy of your medical information. We are also required to inform you about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in the notice while it is in effect. We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we maintain, including medical information we created or received before we made the changes. If we make a significant change in our privacy practices, we will amend this notice and make the new notice available upon request.

A complete copy of Speech Therapy Plus privacy policy can be found in a red binder in the bookshelf in our lobby and on our website. We ask that you would please read the entire notice as it pertains to your rights and protection under the federal health information privacy law (HIPPA). In addition, you have the right to request a printed copy of our privacy notice.

I acknowledge I have been notified of Speech Therapy Plus' privacy policy. I understand this information relates to my rights and protections under the federal health information privacy law. I also understand that I may ask questions at any time regarding my privacy rights as it pertains to services provided by Speech Therapy Plus and request a copy the privacy notice

Patient Name: _____ Date of Birth: _____

_____ _____

Name of Parent/Guardian Relationship to Patient

_____ _____

Signature of Parent/Guardian Date

SPEECH THERAPY PLUS, pllc. POLICY STATEMENT/PATIENT COP Y

Please read and initial each:

1. _____ If you must **CANCEL** a session, please do so **AT LEAST 4 HOURS IN ADVANCE**, otherwise you may be charged a cancellation fee for unexcused absences. **Please make every attempt to reschedule missed sessions**. Please confirm appointments with the front desk if you have any questions regarding your therapy schedule. **You may leave messages 24 hours a day / 7 days a week through our voice mail.**

2. _____ Private pay and insurance co-payments are to be paid in full at the time services are received. Insurance will be billed as necessary.

3. _____ I understand that I will be responsible for any/all charges for provided services in the case that insurance claim submissions are denied for any reason.

4. _____ It is very important to arrive on time for your appointment. Late arrivals will be seen for the remaining period of time for their allotted time schedule. You will still be charged for the full scheduled time.

5. _____ If you have to drop off a patient and leave the premises for any reason, please be back on time. Late arrivals may result in forfeiting your post-appointment consultation with the therapist. Please also make certain we have a cell phone in case we need to reach you.

6. _____ Therapy sessions include a 5-minute consultation with the therapist immediately following a treatment session. For example, a 30-minute session consists of a 25-minute treatment session and then five minutes to discuss the patient's progress.

7. _____ Initial Evaluation appointments and Re-Evaluations are typically one-hour appointments and include a written report with the treatment plan and goals. Re-Evaluations reports with a treatment plan and goals are written every 12 months. Your insurance company may request reports at more frequent intervals which may result in additional charges.

8. _____ You may be asked to remain at the office during the patient's therapy session.

9. _____ The waiting area is equipped with toys and books for everyone's use during the patient's therapy session. **Please make sure they are treated respectfully and returned to their proper storage area.**

10. _____ We ask you to please respect all the patients and therapists that are in therapy sessions by keeping the waiting area reasonably quiet. Please watch your children and never leave them unattended in the waiting room.

Speech Therapy Plus is not responsible for belongings or children left unattended.

11. _____ Please do not allow siblings to accompany the patient into their therapy session.

I have read the above policies and agree to abide by each of them.

Signature Date

Acceptance: LaNee McDonald

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Attendance Policy

It is important that your child attend his/her scheduled appointments in order for speech and language therapy to be effective and positive results achieved.

Speech Therapy Plus requires all patients to maintain a 75% attendance rate.

If you or your child have set appointments scheduled on a reoccurring basis and those appointments are cancelled and/or missed regularly or three (3) consecutive times in a row, we reserve the right to remove you/your child from the schedule.

If we agree to give you the opportunity to reschedule additional appointments, your old appointment schedule may no longer be available and any new appointments will be subject to current availability.

Failure to attend additional scheduled appointments may result in Speech Therapy Plus cancelling our patient/clinic relationship.

While we understand occasionally cancelling an appointment at the last minute may be necessary, our cancellation policy (addressed earlier in these documents) states appointments should be cancelled a minimum of 4 hours prior to the scheduled time. A voicemail message may be left 24 hours a day, 7 days a week when we are not available.

Please sign here acknowledging you understand and accept the attendance policy.

Signature of Parent/Guardian

Date

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Consent to Communicate with Authorized Individuals

I, _____, give my permission to discuss mine or my child's medical condition, results, and history with the following people:

_____ (relation to patient) _____
_____ (relation to patient) _____
_____ (relation to patient) _____
_____ (relation to patient) _____
_____ (relation to patient) _____

This letter is valid for all medical and billing information in my chart / file kept at Speech Therapy Plus, pllc.

_____ _____
Signature of Parent/Guardian Date

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Credit Card Authorization Form

In order for us to process your credit card paynent(s), please complete this form.

Patient Name: _____

Card holder name, if different than patient; _____

Card holder address: _____

Card holder city, state, zip: _____

Card holder phone: _____

Credit card type (select one): ◯ Visa ◯ Mastercard

Credit card number: _____

Expiration date: _____

CVS Security Code (3 digit number on back of card) _____

Name as it appears on Credit Card _____

Statement of Authortzafion
Confidentlal Informatlon

To; Speech Therapy Plus,

I agree to pay for Speech Therapy Treatments for the above named patient on each date services are rendered. I agree to pay the amount determined by insurance or the $70.00 private pay amount per session.

Speech Therapy Plus is authorized to charge the cost of therapy services to my credit card as stated.

Cardholder Signature: _____ **Date:** _____

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11/08/2021

Dear Parents/Patients,

Please be aware we are enforcing and updating our therapy “No Show Attendance” Policy. When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient. We understand that things happen. Therefore, it is important that you call the office within 4 hours in advance to cancel or reschedule your appointment. If for any reason, you need to cancel an appointment, please notify our office as soon as possible. Our therapists are paid “per visit” so they count on you keeping your appointments.

Effective immediately, any patient that does not show up for their scheduled appointment or cancels their appointment less than 4 hours in advance, will incur a $35 charge to their account. Payment of this charge will be required prior to your next scheduled appointment.

We ask that you please sign below and return to our office reflecting your acceptance of this policy. For Medicaid patients, please acknowledge that you waive the “no fee” restriction.

Thank you for choosing Speech Therapy Plus!

I have read the above and understood Speech Therapy Plus, PLLC’s “No Show Attendance” Policy.

Patient/Legal Guardian

Signature Date

Patient Name – Please print