Pediatric Intake

Patient Information

Date:	Name:
Nickname:	DOB:
Sex:	
Mailing Address:	
City:	State:
Zip:	
Parent(s)/Legal Guardian(s)/Legal Responsible Party	
Primary	
Name:	Relationship:
Preferred Phone #	Email address:
Is the address the same as the child's?	
Voicemails	
I authorize Lots of Language to do the following regarding voicemails:	□ Leave detailed messages □ Call back request only □ Do not leave message
Appointment Reminders?	□ Yes □ No □ Email _____
Secondary	
Name:	Relationship:
Preferred Phone #	Email address:
Is the address the same as the child's?	
Voicemails	
I authorize Lots of Language to do the following regarding voicemails:	□ Leave detailed messages □ Call back request only □ Do not leave message
Appointment Reminders?	□ Yes □ No □ Email _____
Physician Name:	Physician Phone Number:
Physician Address:	

Acknowledgement

I have provided accurate information to the best of my knowledge and understand that any information I provide will be used by Lots of Language for the sole purpose of providing my child with an accurate diagnosis pertaining to communication and to provide effective and adequate treatment.

_____ _____/_____/_____

Signature of Patient/Guardian/Responsible Party Date

Financial Policy and Responsibility

We are committed to providing you with the best and affordable Speech-Language Pathology services. Your clear understanding of our Financial Policy is important to our professional relationship. We will gladly discuss our professional fees with you at any time and financial options.
Please note that Lots of Language is a private pay only practice at this time and does not directly accept insurance. We will however provide documentation when requested for reimbursement by your insurance. 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.
Payment:
Payment is expected at the time of service. If payment is not received on day of service your will be charged our full rate and must be paid prior to the next scheduled session. Should payment for services rendered become a financial burden contact us to establish a payment plan. Statements are sent out every 30 days. All accounts that are 120 days past due are automatically sent to collections on day 120. You can request a statement at any time.
Financial Responsible Party: The financial responsible party is responsible for any and all charges incurred. This may include but not be limited to: current private pay rate, no show charges, additional services, etc.
Is the financial responsible party the same as the primary legal party listed above? Yes No
Financial statements/invoices/receipts
I authorize the indicated responsible party to receive financial statements/ invoices/ receipts via: Email Standard Mail
Authorized and valid email/mailing address:
I hereby agree to accept full responsibility for all fees for services rendered by Lots of Language
Signature: **Date:**

Attendance/Cancellation Policy

Lots of Language is dedicated to providing quality Speech-Language Pathology services. We consider regular and consistent attendance an important part in the success of the services we provide.

Your appointment is specifically reserved for you, we appreciate as much notice in advance that you need to cancel an appointment. We understand that sudden illness, emergencies, and last minute scheduling changes occur. When this happens contact your therapist as soon as possible.

No Shows: You will be charged our current no show fee, unless you contact your therapist within 24 hours after your appointment. After 3 consecutive No Show No Contact appointments you will lose your appointment time. You will need to contact your therapist to reschedule, as your appointment time may be filled with another client.

I understand my responsibility for regular attendance. INITIALS _____

General Policies

Clients cannot be left alone with the therapist in the house. Please plan on having an adult present for the duration of the session. We cannot assist your child in the restroom. If your child is not independent in the restroom you must be available should the need arise. You may be asked to provide small materials for therapy such as toys, food, paper, art/school supplies, etc. **INITIALS: _____**

HIPPA/Notice of Privacy Practices

As a legal responsible party I have received, read, and understand the HIPPA/Notice of Privacy Practices policy for Lots of Language. I understand the Lots of Language has the right to change its Notice of Privacy Practices form from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices. **INITIALS _____**		
HIPPA Authorized Persons (other than the parent/legal party(ies) indicated above) I authorized the following person(s) to receive appointment reminders and personal healthcare information. This does not apply to physicians or other healthcare/service providers – a separate release of information will be obtained:		
Please select from the following list: □ Only the parental/legal responsible party(ies) listed above □ The person(s) listed below		
Name:	**Relationship:**	**Phone Number:**
Signature:	**Relationship:**	

Authorizations

Informed Consent for Evaluation and Treatment: I understand and consent to an evaluation and recommended treatment plan. I will be informed of all risks and benefits of any treatment plans prior to implementation. I can choose to not have the recommended treatment plan. If I choose to decline a specific recommended treatment plan I will be asked to acknowledge that in writing. **INITIALS _____**		
Pictures/Video Recordings/Audio Recordings: I give indicated authorizations for photographs/video recordings/audio recordings of the client for evaluative and/or therapeutic purposes only by Lots of Language staff. The following devices may be used but are not limited to: a Lots of Language tablet/computer/camera, or therapist's personal phone/tablet/computer/camera. All photos/recordings made on a personal device will be transferred/uploaded to a Lots of Language flash drive, computer, or clients electronic medical record chart and securely deleted from the privately used device. All photos/recordings will be securely destroyed at parent/client request or upon termination of services. **INITIALS _____**		
Pictures: □ Yes □ No	**Video Recording:** □ Yes □ No	**Audio Recording:** □ Yes □ No

This does not give permission for photos/video recording/audio recording to be posted on any of Lots of Language's website or other social media sites. A separate permission will be obtained for any website or social media purposes.
Confidential Information: I understand that confidential, protected information will not be left on my or any designated authorized contact person's voicemail, text messaging, email, or other electronic medium unless I have requested such in writing. **INITIALS _____**
General Communication: I authorize to receiving, including but not limited to: phone calls, emails, texts re: appointment/scheduling reminders, office notifications, no show messages, etc. that does nto include any confidential, protected healthcare information. **INTIALS _____**
By signing below I have confirmed that I have provided accurate information to the best of my knowledge and accpt all areas indicated
Signature:

Relationship:	**Date:**

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review the carefully. The privacy of your health information is important to us.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on June 1, 2018 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable laws. We reserve the right to make the changes in our privacy practices and the new terms of our notice - effective for all health information that we maintain, including health information we created or received before we made the change. Before we make a significant change in our privacy practices, we will change this notice and make the notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us. **(303)859-2738**

Uses and Disclosures of Health Information

We use and disclose health information about your information about you for treatment, payment, and healthcare operations.

Treatment: We may use and disclose your health information to a physician or other healthcare provider providing treatment to you. For example, if you are sent to us by a physician for speech-language therapy, we will provide a written report of the findings and treatment during the time you are with our services.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may communicate portions of your private health care information in order to operate this facility. For example, we may use your information in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided service to you. We may also provide your information to accountants, attorneys, consultants, and others to make sure we a complying with the laws that affect us.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so by signing a release of information.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up your health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Sign:_____ **Date:**____/_____/_____

Release of Information Form

I _____ (patient or family member) hereby grant _____ (clinician) permission to communicate with the following person or agency:

Name:

_____

_____

Contact Information:

_____

_____

Regarding the following information and as part of their current treatment plan:

□ Previous Medical History

□ Current Medical Concerns

□ Previous Therapy Treatment

□ Current Therapy Treatment

□ Other

Signature _____ **Date** _____/_____/_____