Intake Forms for Speech-Language Therapy & Reading Programs

Date

Child's Name: _____ Date of Birth:_____

Address:_____

Caregiver 1: _____ Caregiver 2: _____

Phone 1: _____Phone 2:_____

Email 1: _____ Email 2: _____

Child lives with (check one):

□ Birth Parents □ Foster Parents □ One Parent
□ Adoptive Parents □ Parent and step-parent □ Other_____

Does your child hear or speak another language besides English? Yes No

If so, what is the primary language spoken at home:_____

Primary language spoken at school:_____

Pediatrician: _____

Phone:_____Fax:_____

Referral Source:_____

Previous evaluation (list):_____

Therapy to date (list):_____

Describe present problem and your main concerns:_____

_____

_____

Who noted present problem? _____When?_____

What is your child's reaction to the problem? _____

_____

How does the family react to the problem?_____

_____

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

If so, what?_____

_____

MEDICAL HISTORY

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

Seizures	High fevers	Measles	Mumps
Chicken pox	Whooping cough	Diphtheria	Croup
Pneumonia	Tonsillitis	Meningitis	Encephalitis
Rheumatic fever	Tuberculosis	Sinusitis	Chronic colds
Enlarged glands	Thyroid	Asthma	Heart Problems
Autism	Intellectual Disability	Dyslexia	Other: Please Explain

Explain any circled items here:_____

_____

Are immunizations up to date? □Yes □No Current general health:_____

** Does your child have a history of many ear infections or ear tubes? □Yes □ No

Please explain here (list ages):_____

_____

Allergies? □ Yes □ No If yes, please explain. _____

Any other serious or recurrent illnesses? □Yes □ No If yes, please explain.

_____

Any surgeries? □ Yes □ No If yes, please explain.

_____

Any accidents? □ Yes □ No If yes, please

_____

Any medications? (Past medications)□Yes □ No If yes, please explain.

_____

(Current medications)_____

Vision problems? _____ Treatment:_____

Hearing difficulties? _____ Treatment:_____

Dental problems? _____ Treatment:_____

Other Medical History:

_____

_____

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 □Feet First

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

_____

DEVELOPMENTAL HISTORY

Age when child: (If you cannot remember specific time, please indicate if it occurred at the expected time or if it was delayed)

sat up alone _____ crawled _____ walked _____ toilet trained _____

dressed self _____ tied shoes _____ fed self independently _____

Weaned from bottle/breast _____ Is the child left or right handed? _____

Any difficulty using: open cup spoon straw

Any difficulty: Swallowing Chewing Drinking Blowing Drooling Food allergies

Favorite Foods:_____

Foods your child will **not** eat (if any)_____

Unusual Feeding Habits? □ Yes □ No If yes, please explain

_____

Attention span-for self-directed activities: _____ Adult-directed:_____

Does your child respond typically to: Light Sound People

Does your child play with others? □ Yes □No Who?_____

- Eat and sleep well? □Yes □No
- Cry appropriately? □Yes □No
- Laugh? □Yes □No
- Smile? □Yes □No
- Make wants/needs known? _____ How?_____

  Does your child show unusual behavior? □yes □no (explain)_____

  _____

  _____

  _____

  _____

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?_____

Does your child say fewer than 15 words? □ Yes □ No If yes, please list:

_____

_____

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 (explain)?_____

_____

Any other developmental challenges? _____

_____

How well is your child understood by: (i.e., what percentage of the time)

Mom:_____ Dad: _____ Younger siblings:_____ Older siblings:_____

Other children:_____ Extended family:_____ Unfamiliar adults:_____

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

_____

_____

SCHOOL HISTORY

Child's Current School and Grade:_____

Child's performance educationally:_____

Receiving special services at school:_____

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

_____

Has the teacher expressed any concern? □ Yes □ No If so, what?_____

_____

OTHER

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

Does the report need to be sent to specific agencies? □ Yes □ No 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. Note: Home address and one phone number are required.

Address _____

Home Phone _____ Ok to leave message: □Yes □No

Primary Caregiver's Name: _____ Relation to patient: _____

Cell Phone_____ Ok to leave message: □Yes □No

Work Phone_____ Ok to leave message: □Yes □No

Email: _____

Secondary Caregiver's Name: _____

Cell Phone _____ Ok to leave message: □Yes □No

Work Phone _____ Ok to leave message: □Yes □No

Email: _____

Please select your preferred contact method (one only):

Appointment Reminders: □ Cell phone □Email:

If you would like text appointment Reminders, what is the best cell phone to send them to?

Cell Phone number: _____

Cell Phone Carrier: _____ (ex: T-Mobile, Sprint)

Email: _____

INSURANCE/PAYMENT INFORMATION

Insurance Carrier:_____

Billing/Claim Address:_____

Benefit/Eligibility Phone Number:_____

Policyholder Name:_____Date of birth (Policyholder)_____

Plan/Program Name:_____

ID Number:_____Policy Group or Number:_____

Secondary Insurance (if Applicable)

Insurance Carrier:_____

Billing/Claim Address:_____

Benefit/Eligibility Phone Number:_____

Policyholder Name:_____

Plan/Program Name:_____

ID Number:_____Policy Group or Number:_____

NOTE: Copies of the policyholder's driver's license and insurance cards may be made at the first appointment.

Assignment of Benefits (insurance patients only):

I,_____ , authorize the release of any payment and medical information necessary to process me or my family member's insurance claim and related claims. I hereby authorize payment directly to Dallas Reading and Language Services of the insurance benefits otherwise payable to me for all professional services.

_____ _____

Signature of Policyholder Date

PARTY RESPONSIBLE FOR PAYMENT

Personal Information:

Name: _____DOB: _____SSN:_____

Address_____

Phone:_____ Employer

Information (if insurance is provided by employer): Company Name:

_____

Company Address:_____

Contact Number:_____

Release of Previous Authorization

Client name: _____
DOB: _____
Medicaid #: _____

There may be other active authorizations for speech therapy services for
through previous service providers. The child is not currently receiving therapy services from any other provider. Any existing authorizations should be canceled.

I affirm that I would like future speech therapy services to be provided by Dallas Reading and Language Services (Rachel Betzen CCC/SLP).

Please cancel/revoke any previous authorizations that would prevent or delay _____ from receiving this care. Please provide an authorization for services based on the recommendations of his most recent Evaluation from Dallas Reading and Language Services.

_____

Parent or guardian Date

Phone and E-mail Reminder Request

This is offered as a courtesy to our clients. If for some reason our system breaks down and the reminder text is not sent, you are still responsible to make the visit. Please choose one method to receive the appt. reminder.

Name of Child/Client: _____

Circle how many days before the visit would you like to receive the reminder:

Same Day 1 Day before 2 Days before

E-mail Reminder

E-mail: _____

OR

Text to phone:

Phone number to receive text message: _____

Phone Carrier (Sprint, AT&T etc)_____

DRLS CONSENT and PAYMENT FORM
This form must be completed before services can be initiated. If the client is under the age of 18 years, this form must be signed by the child's legal guardian(s).

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 Dallas Reading and Language Services. 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 the Policies and Procedures of Dallas Reading and Language Services, 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, and understand its content.

Receipt of Privacy Policy and Consent for Disclosure of Health Information
I have been provided a copy of Dallas Reading and Language Services' 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 Dallas Reading and Language Services' 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, Dallas Reading and Language Services may refuse to treat my child. I further understand that Dallas Reading and Language Services reserve 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.

_____ _____
Patient Signature Date

(If patient is under 18 years of age)

_____ _____
Parent or Legal Guardian Signature Date

Dallas Reading and Language Services

1005 W. Jefferson Blvd. #300
Dallas, TX 75208
sbetzen@dallasreading.com

phone 2 1 4 -646-1570
fax 214-865-6644

Coordination of Care Requirement

As a parent of a child attending speech-language therapy at Dallas Reading and Language Services, I agree to coordinate these services with my child's Primary Care Physician. By agreeing to these terms, I will facilitate in providing the Primary Care Physician with any paperwork that I am asked to share.

I agree to participate fully in at least 90% of Home Exercise Program materials provided to me and my child. By completing a Home Exercise Program consistently, I will help with the carryover of speech-language skills to the home environment. Our therapy staff will be available to answer questions about Home Program Materials.

I have read and understand the provisions of this document. I fully enter into and agree to the above conditions.

Name of child: _____

Name of parent or legal guardian: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Parent or legal guardian's e-mail or phone: _____

_____

Signature of parent or legal guardian Date

Dallas Reading and Language Services

1005 W. Jefferson Blvd. #300
Dallas, TX 75208
www.SpeechTherapyDallas.com

phone 2 1 4 -646-1570
fax 214-865-6644
sbetzen@dallasreading.com

Photo and Media Release Waiver Form

I hereby grant Dallas Reading and Language Services, P.C. their staff and employees, permission to use my minor child's likeness in a photograph and/or video in any and all of their publications, including but not limited to newsletter, social media, and website postings, without payment or any other considerations.

I understand that these photographic, video, or other media publications may be used for public view. I further understand any photographic, video, or other media publication that makes use of my child's likeness will not identify my child by any means other than use of his or her first name, and that my child's last name will not be released to the news media under any circumstances.

I understand that these photographic, video, or other media publications will be the property of Dallas Reading and Language Services and will not be returned.

I authorize the above mentioned to alter, edit, copy, exhibit, publish, or distribute this photo for purposes of publicizing and promoting Dallas Reading and Language Services, P.C. and all functions held under that name. In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my child's likeness appears. Additionally, I waive any right to any royalties or other compensation arising or related to the use of the photograph, video, or other media publications.

I hereby hold harmless and release and forever discharge Dallas Reading and Language Services, P.C. and any person officially representing Dallas Reading and Language Services, P.C. from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other person acting on my behalf or on the behalf of my estate, have or may have by reason of this authorization.

Consent

I have read and understand the provisions of this document. I fully enter into and agree to the above release and waiver and waive any rights there from.

Name of child: _____

Name of parent or legal guardian: _____

Address: _____
City: _____ State: _____ ZIP Code: _____

Parent or legal guardian's e-mail or phone: _____

_____
Signature of parent or legal guardian Date

Welcome to Dallas Reading and Language Services!

Thank you for choosing DRLS to help meet your child's communication and literacy needs. I realize there are many Therapy and Educational Providers to choose from, and I appreciate the opportunity to assist you with this important process.

At DRLS we "Embrace the Amazing in every Child", and help students accept their gifts, as well as develop the tools and skills needed to move through their challenges. Reading Programs are integrated into student's therapy sessions, as appropriate.

The attached New Client Paperwork packet includes important information about our private practice, including insurance, financial and privacy policies. Please take the time to fill out as much information as possible regarding your child's developmental history. This information can be vital to the direction of the therapy plan. We understand these forms can be time consuming; however it is important to have as much information as possible, to help us provide the best services 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 fax them to our office.

Completed form packets may be faxed to: 214-646-1570
E-mailed to: rbetzen@dallasreading.com
Or mailed to: 1005 W. Jefferson Blvd Suite 300, Dallas TX 75208

Please feel free to call or e-mail Rachel Betzen, DRLS owner and Speech-Language Pathologist, with any questions or concerns regarding this packet.

I look forward to working with you and making a difference in your child's

life! Sincerely,

Rachel Betzen CCC/SLP

Rachel Betzen M.A. CCC/SLP

Licensed Speech-Language Pathologist

TX License #101794

ASHA Certification #12103270
TSHA Member #21204

POLICIES AND PROCEDURES

Appointments
If you must cancel an appointment that you have scheduled, **please call immediately**. Except under emergency circumstances, contagious illness, or where prohibited by law or contract, all appointments canceled with less than 24 hours notice will be subject to a $25 service fee per 30 minute session. For no call no show there will be a $50 service fee per 30 minute session. In the event that you arrive late for your appointment, I will do my best to see you, however the appointment may be shortened due to time constraints; the full session fee still applies. Please note that most insurance companies will not reimburse for missed appointments and you will remain responsible for these charges.

Confidentiality
Your privacy is very important to us. We recommend that you review the Notice of Privacy Policy for important details regarding policies for maintaining confidentiality. In particular, you should be aware that I will only contact you via means that you have specifically authorized in your new client paperwork. If you would like me 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. Families that have a co-pay for services will be informed of their payment amount and the number of therapy visits authorized by their insurance plan.

Payment
The person who completes the Party Responsible for Payment section is responsible for payment of all services rendered. In most cases, payment is due at the time services are rendered unless you have made other arrangements in advance. Unless arrangements have been made, accounts more than 30 days overdue will be subject to a $20 late fee and accounts more than 60 days overdue will be sent to collection. For clients seeking third-party reimbursement please be aware that you are ultimately responsible for the payment of services rendered. In the event that your insurance carrier denies payment (including recoupment) or does not remit payment within 45 days, the client will be responsible for
payment of all services rendered. Dallas Reading and Language Services may at times provide discounts or fee waivers for families with extenuating circumstances; however, it is the client's responsibility to ensure that acceptance of such fee reductions will not adversely affect third-party payment obligation. We encourage private pay families and those who have used all their allowable visits, to use our sliding scale.

Health Insurance
Dallas Reading and Language Services participate with some insurance companies, but not all. In the event that we do not accept your insurance, 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.

Termination of Services
Services may be terminated:

- In the event that you do not keep your financial obligations to Dallas Reading and Language Services and remain delinquent on your account for more than 60 days, services will be suspended until payment is received.
- If it is determined that continued participation will be a detriment to our employees, other clients, the child or their family.
- If client/client's family misses 2 or more therapy visits without notifying Dallas Reading and Language Services of their cancellation.
- If client's family develops a pattern of tardiness, cancellations or any other activity that has a detrimental impact on our operations.

If you have extenuating circumstances, please contact us as soon as possible. Our number one goal is to provide services that have a lasting change in your child's life.

Health Policy
Help and cooperation is required in order to maintain a healthy environment. If sick, 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.

Children should not come to therapy 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 of 100.4 or more
- Vomiting or Diarrhea

If your child becomes ill, please contact us to reschedule therapy as soon as possible.

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. Dallas Reading and Language Services is required to abide these policies until replaced or revised. Dallas Reading and Language Services has 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, or counseling session are covered by the law as private information. Dallas Reading and Language Services 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 Dallas Reading and Language Services 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 Dallas Reading and Language Services 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.

ExceptionstoReleaseofprotectedhealthinformationinclude:

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.

In the Event of a Client's Death

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child or spouse's records.

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 meeting is being held regarding the health care professional's actions, related records may 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, only the minimally acceptable amount of information will be revealed. Additionally, if a client files a complaint or lawsuit against anyone affiliated with Dallas Reading and Language Services; 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

When payment for services is the responsibility of the client, or a person who has agreed to provide payment and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the time-frame, and the name of the clinic or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, summaries or copies of the entire clinical record. Only the minimally acceptable amount of information will be released to accommodate such requests.

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. Some progress notes and reports are dictated/typed within the practice or by outside sources specializing in (and held accountable for) such procedures.

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 than the client or the client's legal guardian) unless Dallas Reading and Language Services has received written authorization to do so.

Your Rights as a Legal Guardian

- 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 minors must be requested by their custodial parents or legal guardians. We reserve the right to charge up to $.50 per page, plus postage.
- You have the right to cancel a release of information by providing Dallas Reading and Language Services with 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. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your child's file.
- 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 DRLS. We will get back to you in a timely manner. If you believe your privacy rights have been violated, complaints should also be directed to the management at Dallas Reading and Language Services.
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 Dallas Reading and Language Services or the Office of Civil Rights.

Your Rights as a Patient

As a recipient of services at Dallas Reading and Language Services, 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 Dallas Reading and Language Services 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. Dallas Reading and Language Services 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. Dallas Reading and Language Services will always inform you of charges before we provide a service.
- 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 Dallas Reading and Language Services' 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.