5757 Flewellen Oaks Lane, Suite 604, Fulshear, Texas 77441
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Child Intake Form / History

Child's Name: _____ Today's Date _____
Date of Birth: _____ Age: _____ ☐ Male ☐ Female
Diagnosis (if known): _____
Address: _____
City, State, Zip: _____

Emergency Contact Name: _____
Relationship to Child:_____ Contact Number: _____

Child's Physician: _____
Physician Phone Number: _____
Physician Fax Number: _____
Physician Address: _____

How did you hear about *Growing Speech, PLLC and/or HCSPEECH*?
_____

Family Background
Parent 1 Name: _____ Age: _____ D.O.B. _____
Phone #1:_____ ☐ Cell ☐ Home ☐ Work ☐ Other
Email #1:_____
Occupation: _____ Education Level: _____
Parent 2 Name: _____ Age: _____ D.O.B. _____
Phone #2:_____ ☐ Cell ☐ Home ☐ Work ☐ Other
Email #2: _____
Occupation: _____ Education Level: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

What adults does the child live with? Check all that apply:
☐Birth Parent(s) ☐Adoptive Parent(s) ☐Foster Parent(s)
☐Grandparent(s) ☐Both Parents ☐Parent 1 Only
☐Parent 2 Only ☐Other: _____

Does the child have siblings or are there other siblings in the home?
Child 1 Name: _____ Age: __ Sex: __ Speech Issues:_____
Child 2 Name: _____ Age: __ Sex: __ Speech Issues:_____
_____

Language(s) spoken in the home: _____
Who speaks the other language(s)? _____
Describe the child's use/understanding of the language(s): _____
_____

Evaluation
Briefly describe why you are seeking an evaluation and what your concerns are:
_____
_____

Has the child had a previous speech, language or feeding evaluation / treatment?
☐Yes ☐No By whom: _____When: _____
Describe the results: _____
_____

At what age did you first notice the problem? _____

If anyone else in the family has a speech or language diagnosis, please describe it:
_____
_____

Medical History

Mother's Health During Pregnancy:
1. Were there any infections or illnesses? ☐ Yes ☐ No
Describe: _____
2. Were there any complications during labor or delivery? ☐ Yes ☐ No
Describe: _____
4. What was the mother's age at the time of delivery? ____ years

Child's Health:
1. How many weeks gestation was the child born? ____ weeks (40 weeks is typical)
2. The child was _____ lbs ____oz and _____ inches at birth
3. How was the child delivered? ☐ Vaginally ☐ Cesarean Section
4. Has the child's hearing been tested? yes/no Date: _____ Results: _____

Check and describe all that apply:

☐ Allergies _____ _____
☐ Adenoidectomy _____
☐ Asthma _____
☐ Behavior Issues _____
☐ Brain injury _____
☐ Breathing problems _____
☐ Cardiac issues _____
☐ Chicken pox _____
☐ Diabetes _____
☐ Ear infections_____
☐ Ear tubes _____
☐ Encephalitis_____
☐ Frequent colds_____
☐ Hearing aids _____
☐ Hearing loss_____
☐ High fever _____
☐ Measles _____
☐ Meningitis _____
☐ Mumps _____
☐ Seizures _____
☐ Sensory issues _____
☐ Sleep issues_____
☐ Tongue tie _____
☐ Tonsillitis _____
☐ Tonsillectomy_____
☐ Traumatic brain injury_____
☐ Vision issues _____

Describe any other pertinent information not listed above about the child's medical history (surgeries, hospitalizations, serious accidents, chronic illnesses, diagnoses, etc.) as well as when they were diagnosed and by whom:

_____
_____

Is the child currently on any medications? If so, please list **medication name** and **reason** for medication:

_____
_____

Does the child currently use any equipment? (communication device, walker, etc.)

☐No ☐Yes, please describe: _____

Describe the child's current health status: good/fair/poor _____
_____

Is the child currently receiving any of the following services? If yes, please list the person's name and last date of service.

☐Developmental Pediatrician _____
☐Neurologist _____
☐Physical Therapy _____
☐Occupational Thearpy_____
☐Speech Therapy _____
☐Behavioral Therapist _____
☐Psychiatrist / Psychologist _____
☐Other: _____

Developmental History

At what age did the child do the following:

Sit alone: _____ Crawl: _____
Stand Up: _____ Walk: _____
Babble: _____ First Word: _____
Combined Words: _____ Sentences: _____
Fed Self: _____ Understood by Others:_____
Toilet Trained: _____ Dressed Self: _____

Does the child do any of the following:

☐ Difficulty with liquids ☐ Difficulty with solids
☐Avoid foods ☐Maintain a special diet
☐Use a pacifier / suck thumb ☐Mouth objects
Please describe any of the above: _____
_____

How many words does the child say:

☐0-20 ☐21-50 ☐51-100 ☐101-150
☐151-300 ☐301-500 ☐501+

Does the child produce sentences of the following length:

☐ 2 words ☐ 3 words ☐ 4 words ☐ 5+ words

What percentage of the child's speech do you understand? _____%
How well do people outside of the family understand his/her speech? _____%

If the child is not using words, how does he/she communicate? _____
_____

Does the child have any difficulty with the following:

☐ Attention ☐ Aggression
☐ Angerq ☐ School work
☐ Answering simple questions ☐ Maintaining eye contact
☐ Understanding people ☐ Following directions
☐ Excessive drooling ☐ Transitions
☐ Producing speech sounds ☐ Stuttering
☐ Reading ☐ Other difficulties: _____
☐ Memory
Please describe any of the above: _____
_____
_____

Educational History

Is the child currently enrolled in daycare/ school: ☐ Yes ☐ No Grade: _____
Name of school: _____

Please describe any educational difficulties, learning challenges, or accommodations required: _____
_____

Social History

Describe how the child interacts with parents, siblings, or other family members:
_____
_____

Please describe the communication difficulties the child faces in the home environment:
_____
_____

Describe any significant events or changes within the home: _____
_____
_____

What are the child's
strengths? _____
_____
weaknesses? _____
_____

What are the child's favorite activities? _____
_____

Does the child become easily frustrated with certain activities? If so, please explain:
_____
_____

Describe how the child interacts with other children: _____
_____

Person filling out the form: _____

Relationship to the child: _____

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PRIVACY NOTICE

Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information.

PLEASE REVIEW CAREFULLY

Who will follow this notice:

1. Any health care worker authorized to enter information into your chart including practicing physicians and other credentialing individuals who are part of the Organized Health Care arrangement that participates in providing care and assisting Growing Speech, PLLC and Houston Corporate Speech Pathology, PLLC operational activities.
2. Business associated affiliated with Growing Speech, PLLC and Houston Corporate Speech Pathology, PLLC
3. All employees and staff members of Growing Speech, PLLC and Houston Corporate Speech Pathology, PLLC

Our pledge regarding your information: Understand that information about you and your health are personnel and considered Protective Health Information (PHI). We are committed to protecting information about you. We are required by law to create and maintain a record of the care provided by Growing Speech, PLLC and Houston Corporate Speech Pathology, PLLC. How we may use and disclose information: This notice describes different ways we use and disclose PHI. Not every use or release will be listed. However, all of the ways that we are allowed to use and disclose information will be stated. We may use PHI (including information from previous treatment) to provide medical treatment or services. We may disclose information to your doctors, students, technicians, therapists, and therapy assistants or other Growing Speech, PLLC and/or Houston Corporate Speech Pathology, PLLC employees who may be involved in your care. We may also disclose to people outside of Growing Speech, PLLC and Houston Corporate Speech Pathology, PLLC who may be involved in your medical care after you leave such as any members or others we use to provide services. We may use and disclose PHI about you to create bills and payments. We may contact insurance companies to inquire or verify coverage. We may contact you to remind you of your appointments for clinical follow ups and for customer service. We may release PHI to a family member who pays for your care. We have to disclose PHI when required by federal, state, or local laws. We are required to disclose PHI to health authorities to prevent a serious threat to your health and/or safety of the public or another person. We may release information to the military and workmen's compensation. PHI may be released for public health issues. We may release information the coroner, medical personnel or for national security and intelligence.

Your rights regarding information about you: We have the right to review and copy information about you. We require a written request to inspect and copy PHI. If any information about you is incorrect or incomplete you can request an amendment as long as the information is kept by or for Growing Speech, PLLC and/or Houston Corporate Speech Pathology, PLLC. You also have a right to receive an accounting of disclosure. You can request in writing a notification on where we disclose PHI. You can request that we contact you at a specific location or in a certain manner. You have a right to a paper copy of this notice. We reserve the right to make changes to this notice and continue to maintain confidentiality of all healthcare information. We disclose the effective date on this notice. Uses and disclosures of PHI will be made only with your written permission.

If you have any questions or you want to file a complaint, please contact Growing Speech, Houston Corporate Speech Pathology, PLLC, or contact the Texas Department of Health and Human Services (toll free) at 1-800-735-2989. You will not be penalized for complaint.

Signature of Patient/Parent/Legal Guardian	Date	Signature of Witness	Date

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Acknowledgement That You Have Received Our HIPAA Privacy Notice

Growing Speech, PLLC and Houston Corporate Speech Pathology, PLLC are required by law to keep your health information and records safe.
This information may include:

- Notes from your doctor, teacher or other healthcare provider
- Medical history
- Test results
- Treatment notes
- Insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information may be used and shared.

☐ **I acknowledge that I have received a copy of *Growing Speech, PLLC*'s and *Houston Corporate Speech Pathology, PLLC*'s HIPAA Notice of Privacy Practices that fully explains the uses and disclosures they will make with respect to my individually identifiable health information.**

☐ **I have had the opportunity to read the notice and to have any questions regarding the notice answered to my satisfaction.**

☐ **I understand *Growing Speech, PLLC* and *Houston Corporate Speech Pathology, PLLC* cannot disclose my health information other than as specified in the notice.**

☐ **I understand that *Growing Speech, PLLC* and *Houston Corporate Speech Pathology, PLLC* reserves the right to change the notice and the practices detailed therein if it sends a copy of the revised notice to the address I have provided.**

_____ _____
Print Name of Patient Date

_____ _____
Signature of Patient or Legal Representative Relationship to Patient

Please Note: It is your right to refuse to sign this Acknowledgement.
HIPAA Privacy Notice Acknowledgement

_____
Office Use Only

I tried to obtain written Acknowledgement of our Privacy Notice by the patient/legal representative noted above. It could not be obtained for the following reason(s)

- An emergency prevented us from obtaining acknowledgement.
- The individual was unwilling to sign.
- A communication barrier prevented us from obtaining acknowledgement.
- Other: _____

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Attendance / Cancellation Policy

Attendance and participation in therapy along with complete compliance with any associated home programs are essential for therapeutic success.

While *Growing Speech, PLLC* and *Houston Corporate Speech Pathology, PLLC* understand that illnesses and emergencies occur, we respectfully request that you avoid frequent cancellations or "no shows". Please adhere to our following policy regarding providing our office with advance notification for any cancellations resulting from a conflicting appointment, vacation, or any other event.

All cancellations must be submitted 24 hours prior to your scheduled appointment.

☐ A **fee of $20** may be assessed if the following occurs:

- If cancellations are made less than the required 24 hours.
- If the client fails to show up for a scheduled appointment.

This fee will be billed directly to the client and not to their health insurance company, as medical insurance does not provide coverage for missed sessions.

☐ If you miss / reschedule / are late for 3 scheduled appointments, the office reserves the right to discharge the client. Additionally, if you arrive late for a scheduled appointment, the session will still end at the scheduled time or may be cancelled.

☐ I, _____, understand the attendance / cancellation policy and the risks of not adhering to it.

_____ _____
Print Name of Client Date

_____ _____
Signature of Participant or Legal Representative Relationship to Client

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Payment Policy

Thank you for choosing our private practice to serve you. We are committed to providing you with the highest quality care. Please know that the timely payment of your bill is an integral part of our service and as such, this payment policy is an agreement between you and *Growing Speech, PLLC* and/or *Houston Corporate Speech Pathology, PLLC* for payment of services provided. By signing this policy, you are agreeing to pay for services provided to you or your family member. As a client of *Growing Speech, PLLC* and/or *Houston Corporate Speech Pathology, PLLC* you are required to carefully review and sign our payment policy.

Please read the following information carefully:

All therapy fees (including session fees and/or co-pays, if applicable) are due at the time of service.

We accept the following payment methods at this time: credit card or check (Checks should be made payable to *Houston Corporate Speech Pathology, PLLC or Growing Speech, PLLC).*

We will provide you with an invoice outlining the services rendered and the amount charged.

Please read and check all boxes to acknowledge understanding and sign below:

☐ I understand that I am responsible for all costs / fees that any third-party payer (ex. insurance company, private school, etc.) does not cover. In the event that a third-party payer source determines that rendered therapy services are “not covered” or otherwise denied, I will be responsible for all outstanding charges. I understand that I will be billed accordingly and will be responsible for immediate payment. I also understand that *Growing Speech, PLLC* and/or *Houston Corporate Speech Pathology, PLLC* will not become involved in disputes between you and your third-party source regarding uncovered charges or reasons for denial.

☐ I understand that if fees are not paid in full, treatment sessions may be postponed or cancelled until payment is received.

☐ I understand that all returned checks will be subject to a $30 returned check fee. Charges incurred and not paid after 14 days may be turned over to a collection agency at the client's expense. Overdue accounts may also be reported to a Credit Bureau.

☐ I understand that I am responsible for all legal and collection fees, which *Growing Speech, PLLC* and/or *Houston Corporate Speech Pathology, PLLC* may incur if payment is not made in accordance with the terms and conditions herein.

☐ I understand that refunds will be issued only in instances of overpayment. All refunds will be processed within 2 weeks after the overpayment is discovered on the client's bill or at the time the refund is requested. Refunds for payments made with a credit card will be credited back to the credit card used, all other refunds will be issued by a check. Clients who used a third-party source will not be issued a refund until full payment is received from the appropriate source.

☐ I, _____, (client / guardian name) understand the payment policy and the risks of not adhering to it.

☐ I, _____, authorize *Houston Corporate Speech Pathology, PLLC* and/or *Growing Speech, PLLC* to charge my credit card for agreed upon purchases for session fees. I understand that my information will be saved to my account for future transactions. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

_____ _____

Print Name of Client Date

_____ _____

Signature of Client, Guardian or Responsible Party Relationship to Client

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Equipment Use Waiver

It is our goal to promote a fun and safe environment for our children during therapy. However, there are inherent risks associated with the use of our therapeutic space (e.g. furniture, toys, therapeutic ball, etc.). While we provide therapy in the safest manner possible, the risk of injury from use of our therapeutic space is possible.

By signing below, I understand:

- Therapeutic materials are provided to reinforce and improve my child's communication
- Rules for use are explained to my child and supervision while in use is provided at all times.
- I assume all risks and hazards incidental to participation with use of therapeutic tools, I do hereby waive, absolve, indemnify and agree to hold harmless Growing Speech, PLLC and Houston Corporate Speech Pathology, PLLC and any partners, employees, managers, and affiliates- except to the extent and in the amount covered by liability insurance.
- I understand medical insurance is NOT provided by Growing Speech, PLLC and Houston Corporate Speech Pathology, PLLC should injury occur.
- I understand that should significant injury occur as a result of use, 911 will be the initial call followed in order by the persons listed on this form below.

Please read carefully and sign to indicate your agreement. Note: This form includes a release of liability.

For and in consideration of my child being permitted to participate in therapeutic and reinforcement activities, I hereby voluntarily release, discharge, waive and relinquish any and all claims or actions for damages for personal injury, permanent disability, death, or property damage which I or my child may have, or which may hereafter accrue to me or my child, as a result of my participation in therapy during play, and while I am at the facility while others play, or for any other reason. This release is intended to discharge, in advance, Growing Speech, PLLC and Houston Corporate Speech Pathology, PLLC and it's officers, employees and agents, and the owners and maintainers of any facility used for therapeutic activities, from any and all

liability arising out of or connected in any way with my child's participation in therapy, camps, clinic activities, even though that liability may arise out of negligence or carelessness on the part of Growing Speech, PLLC and Houston Corporate Speech Pathology, PLLC and its officers, agents or employees, or the owners or maintainers of any facility used by Growing Speech, PLLC and Houston Corporate Speech Pathology, PLLC for therapeutic activities.

I further understand that serious accidents occasionally occur during therapeutic activities, and that participants occasionally sustain serious personal injuries, death or property damage as a consequence thereof. Knowing the risks, I have voluntarily applied for my child to participate in the activity and thereby agree to assume those risks to release and hold harmless Growing Speech, PLLC and Houston Corporate Speech Pathology, PLLC, its officers, employees or agents, or the owners or maintainers of any facility used by Growing Speech, PLLC and Houston Corporate Speech Pathology, PLLC for therapy and reinforcement activities, who (through negligence or carelessness) might otherwise be liable to me or to my child (or my heirs or assigns) for damages.

I further understand and agree that this release, discharge, waiver, and assumption of risk is to be binding on my and my child's heirs, executors, administrators, and assigns. I further agree to indemnify and to hold harmless Growing Speech, PLLC, Houston Corporate Speech Pathology, PLLC, its officers, employees and agents, or the owners or maintainers of any facility used by Growing Speech, PLLC and Houston Corporate Speech Pathology, PLLC for treatment, fundraising, or therapeutic activities, for any loss, liability damage, cost or expense which may incur as a result of any injury or property damage I or my child may sustain while participating in the activity.

I agree to comply with the program's stated and customary terms and conditions for participation according to Growing Speech, PLLC and Houston Corporate Speech Pathology, PLLC. If I observe any significant change with regards to my child's readiness for participation in the program, I will remove my consent immediately.

I have read this Informed Consent/General Release, fully understanding its terms, that I give up substantial rights by signing it, and sign it voluntarily. By my signature below, I certify that I have read, fully understand and accept all terms of the foregoing statement.

_____ _____

Signature of patient/parent/legal guardian Date

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Consent for Services

☐ I **authorize** *Growing Speech, PLLC* and/or *Houston Corporate Speech Pathology, PLLC* to render appropriate evaluation and therapy services to the client named below in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained health professional. I recognize, agree and understand that I have the right to refuse treatment or terminate services at any time by *Growing Speech, PLLC* and/or *Houston Corporate Speech Pathology, PLLC* in writing. In addition, *Growing Speech, PLLC* and *Houston Corporate Speech Pathology, PLLC* may terminate services by notifying me in writing.

- ❏ I grant permission for my child to be photographed at *Growing Speech, PLLC* and/or *Houston Corporate Speech Pathology, PLLC* during normal business hours or activities. I understand that these photographs may be used in promoting services, either in print or on the Internet.
- ❏ I do not grant permission for my child to be photographed for promoting services.

☐ I **do not** give my consent or am withdrawing my consent regarding *Growing Speech, PLLC* and/or *Houston Corporate Speech Pathology, PLLC* rendering evaluation and therapy services to the client named below.

_____ _____
Print Name of Client Date

_____
Client Date of Birth

_____ _____
Signature of Client or Legal Representative Relationship to Client

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Authorization to Exchange, Obtain, or Release Information

Client Name: _____ Date of Birth: _____
Home Address: _____
_____

For the reasons identified in this form, I _____ (client or family member) hereby grant *Growing Speech, PLLC* and *Houston Corporate Speech Pathology, PLLC* permission to communicate (exchange, obtain, or release) my medical information with the following professionals:

- ❏ Pediatrician (i.e. Medical History)
- ❏ Specialists (i.e. OT, ABA therapists, neuropsychological records, etc.)
- ❏ School (i.e. Evaluations, IEPs, etc.)

For the purpose of coordinating care with other professionals, providing continuity of services, and updating therapeutic progress.

☐ I grant permission for the exchange of information between professional via written, mailed report, phone call, meeting, email, or fax.

☐ I understand that this authorization will remain valid until written revocation of this authorization is presented.

_____ _____
Print Name of Client Date

_____ _____
Signature of Participant or Legal Representative Relationship to Client