Center for Speech & Language Pathology, LLC
600 Saint Clair Ave., Building 6
Huntsville, AL 35801
(256) 533-3314
CenterForSpeech.net

CSL Child Intake Form

Today's Date:________________________

Patient's Name: ☐ Male ☐ Female	Name Child Goes By:
Address:	DOB:
City, State, Zip:	Age:

Mother/Guardian:	DOB:
Address, if different than patient's:	SS#
City, State and Zip:	Phone:
Employer:	Work Phone:
Email Address:	Cell Phone:

Father/Guardian:	DOB:
Address, if different than patient's:	SS#
City, State and Zip:	Phone:
Employer:	Work Phone:
Email Address:	Cell Phone:

Emergency Contact :_________________________ Phone: _________________ Relationship: _________________

Sibling:	Age:
Sibling:	Age:
Sibling:	Age:

Primary Insurance:

Insurance Carrier:____________________________________ Name on Card:____________________________________

DOB:_____________________ Contract Number:______________________________ Group Number:______________

Secondary Insurance:

Insurance Carrier:____________________________________ Name on Card:____________________________________

DOB:_____________________ Contract Number:______________________________ Group Number:______________

Child lives with (check one):

____ Birth Parents ____Foster Parents ____One Parent (___________)

____ Adoptive Parents ____Parent and Step-Parent ____ Other_________________

Preferred phone number to contact: ______________________

Would you like to receive a courtesy reminder call for every scheduled appointment? ***Yes*** ***No***

CHILD HISTORY

Age of mother at child's birth:_______________ Age of father at child's birth:_______________________

During pregnancy did mother: (Please circle.)

smoke use alcohol use medication If yes, please list:___________________________

Length of pregnancy _____________weeks. Birth weight:___lbs. ____oz. Was this a twin birth? ***Yes*** ***No***

How long was child hospitalized after birth?____

Please describe any birth injury or abnormality:

Is this child adopted? ***Yes*** ***No*** If yes, at what age:_____________________________

in foster care? ***Yes*** ***No*** If yes, how long:_______________________________

Please circle if your child has been **diagnosed** with any of the following:

allergies	chronic colds	respiratory problems	asthma
pneumonia	croup	draining ear(s)	ear infections
PE tubes	sinusitis	cognitive impairment	high fever
dizziness	seizures	convulsions	meningitis
tinnitus	visual problems	ADD/ADHD	dyslexia
autism/PDD NOS	Asperger's	learning disabilities	emotional disorders
cleft lip/palate	hearing impairment	genetic syndrome	other:________________

Has the child had any surgeries? ***Yes*** ***No*** If yes, what type, when and by whom?_____________

____

Describe any major accidents or hospitalizations. Include length of hospitalization.___________________________
____

Is your child taking any medication? ***Yes No*** If yes, please list medications:_____________________
____

Has the child had a speech-language evaluation before? ***Yes No***
If yes, when?____________ where? ***school clinic other***_____________________________

Is the child *currently* receiving speech therapy services? ***Yes No*** If yes, where? ____________________
How long? _______ years _____months How often? _____ times weekly for _______minute sessions

Has the child received speech therapy services *in the past*? ***Yes No*** If yes, where? ____________________
How long? _______ years _____months How often? _____ times weekly for _______minute sessions

Has a hearing evaluation been conducted? ***Yes No***
If yes, when?______ What were the results? ***Normal Impaired***

If impaired, please explain:____
____

Who is the daytime caregiver(s) for this child? (Circle all that apply.)

mom dad grandparent daycare program babysitter family member

other, please specify____

Child's school:____ Grade:_____________________

Is your child in a special education classroom and/or receiving special education services? ***Yes No***
If yes, please describe:____

Did your child:	Yes	No	If no, at what age:
hold his/her head up by four months			
crawl by twelve months			
toilet-train by three years			
sit alone by twelve months			
eat solid food by twelve months			
feed self by two years			
respond to name/peek-a-boo by eight months			
imitate sounds by twelve months			
say first word by fifteen months			
walk alone by sixteen months			
say two words together by twenty-four months.			

Does your child have a thumb/finger sucking habit? ***Yes No***

Is there a language other than English spoken in the home? ***Yes*** ***No***

If yes, which language(s)? ______________________________

Does the child speak the language? ***Yes*** ***No***

Does the child understand the language? ***Yes*** ***No***

Who speaks the language? ______________________________

Which language does the child prefer to speak at home? ______________________________

What do you see as your child's most difficult speech problem in the home? ______________________________

____

What do you see at your child's most difficult speech problem in school? ______________________________

____

Who referred you to the Center for Speech and Language Pathology? ______________________________

Child's Physician:______________________________Phone:__________________

Who will be responsible for payment of speech therapy services?______________________________

Name of person completing this form:____________________________ relationship to patient:________________

Your Signature:______________________________ Date:____________

Center for Speech and Language Pathology, LLC
Rates for Service

Service	Rate
Fluency Evaluation	$150
Articulation Evaluation	$150
Articulation and Language Evaluation	$250
Voice Evaluation	$150
Swallowing Evaluation	$200
Aphasia Evaluation	$200
Therapy	$ 95

Center for Speech and Language Pathology, LLC will bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when services are rendered. We require that arrangements for payment of the estimated share be made today. If your insurance carriers do not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company denies services, you will be responsible for any balance.

In the event your insurance company establishes an Internal Usual and Customary (UCR) fee schedule, you will be responsible for the difference in the actual fee and the UCR. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit it to the Center for Speech and Language Pathology, LLC. Please understand that our relationship is with you and not your insurance company.

If you prefer to not have your insurance filed or your insurance does not cover speech therapy, we do offer a discount for services **paid in full at the time of service**. These fees are as follows:

Service	Rate
Fluency Evaluation	$125
Articulation Evaluation	$125
Articulation and Language Evaluation	$225
Voice Evaluation	$125
Swallowing Evaluation	$175
Aphasia Evaluation	$175
Therapy	$ 75

Please understand these rates only apply if insurance is not filed and payment is made in full at the time of service. This DISCOUNT is offered only for those patients who PAY in FULL ON THE DAY OF SERVICE.

Please make your checks payable to Center for Speech. For the safety of our staff and internal controls, we prefer not to accept cash payments. If you must make payments in cash, please request a numbered receipt and keep all copies for your records.

All checks returned due to insufficient funds will be subject to a $35 fee. Charges incurred and not paid after ninety (90) days may be turned over for collection.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENTS TO MY ACCOUNT.

______________________________________ ____________________
Signature Parent/Guardian/Responsible Party Date

______________________________________ ____________________
Center Representative/Witness Date

Center for Speech & Language Pathology, LLC
600 Saint Clair Ave. SW, Building 6
Huntsville, AL 35801
(256) 533-3314
CenterForSpeech.net

APPOINTMENT POLICY

Thank you for trusting your medical care to the Center for Speech and Language Pathology, LLC. We strive to provide excellent medical care to you and all of our patients. In order to be consistent with this philosophy, we use an appointment system that sets aside ample time for a patient dependent on the patient's current needs.

If you do not show up for your appointment or notify us of your inability to keep your appointment in advance, the time that has been allotted for your visit cannot be used to treat another patient and is time lost to our office. With that in mind and in order to keep costs as low as possible, an Appointment Policy has been put in place. Our policy is as follows:

Non-emergency cancellations require 24 hours' notice. Non-emergencies include vacations, preplanned medical appointments, family events, parties, sports events, dance class, lack of a babysitter, or anything that is not designated as "emergency" (see below). The session **MUST** be canceled **no later than 24 hours before the appointment**. **No exceptions**. If non-emergency cancellations become excessive, the patient may lose his/her weekly slot in the clinician's schedule. **If the session is not canceled with 24 hours' notice you will be charged $45**. Insurance does not pay this charge.

Emergency cancellations are accepted only for illness, illness of a family member, or a death in the family. These sessions must be canceled by 9:00 a.m. on the day of the appointment. Please do not come to the office with a fever, strep, unidentified rash, diarrhea, vomiting, or any highly contagious illness. Patient must be fever-free for 24 hours prior to the session. If you arrive ill, you will be dismissed and charged the $45 cancellation fee for the session.

Promptness is important. Clinicians only have 30 minutes per session. If you are more than 10 minutes late for your session, there is not enough time for a productive session and insurance will not pay for your therapy. If you arrive 10 minutes or more past your appointment time, you will not be seen and you will be charged a $45 fee for a missed appointment.

Because this office holds a time for your session, you are essentially promising to fulfill that slot. We take careful attendance. If you exceed a cancellation rate of 25 percent or higher, you will receive written notice that your slot is in jeopardy, especially if you do not schedule or attend make-up sessions. This policy includes emergency and non-emergency cancellations.

As a courtesy, we make reminder calls for your appointments. If you do not receive a reminder call or message, the cancellation policy will still remain in effect.

I have read and understand the Appointment Policy and agree to be bound by its terms.

____ ____________________
Signature of Responsible Party Date

____ ____________________
Center Representative/Witness Date

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ASSIGNMENT OF BENEFITS: I voluntarily direct ____________________________________ Insurance company to pay the Center for Speech and Language Pathology, LLC directly for charges for professional services rendered to me. THIS IS A DIRECT ASSIGNMENT OF BENEFITS UNDER THIS POLICY. I agree that I am responsible for any balance over and above insurance payment for these services. I authorize the Center for Speech and Language Pathology, LLC, to initiate a complaint to the Insurance Commissioner for any reason on my behalf. I understand and agree that if collection efforts are necessary to obtain payment on this account, I will be responsible for all costs of such collection efforts, including reasonable attorney fees. I understand that any unpaid balance will accrue monthly interest at 1.5-% after 30 days of delinquency, unless prior payment arrangements are made.

Driver's License Number: ____________________________ State: _____

CONSENT TO TREAT: I voluntarily authorize the Center for Speech and Language and whomever the center designates as assistants or associates to administer examinations and care as deemed necessary for my condition.

Emergency Contact Name:
____Phone:________________________

AUTHORIZATION TO RELEASE RECORDS: I voluntarily authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in my case.

____ ____________________________
Patient Name Date

____ ____________________________
Patient or Parent/Guardian Signature Date

____ ____________________________
Witness Signature Date

Center for Speech and Language, LLC
600 Saint Clair Ave. SW, Building 6
Huntsville, AL 35801
256.533.3314 Phone
256.533.3384 Fax

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

The medical records cannot be released until this form is completed and signed by the patient or legal guardian.
You must complete this form thoroughly.

PLEASE PRINT
Step I: Patient Name___________________________________ Date of Birth_________________________

Address____
Street City State Zip Code

Step II: I hereby authorize Center for Speech and Language, LLC _____ to release or ____ to obtain my health information.

Name of Physician/Medical Facility____

Address ____
Street City State Zip Code Phone # Fax #

Step III: Information to be released: ____
Date (s)/Condition (s)

____Continuity of Care Reason: ____

____Transfer of Care

CONDITIONS OF AUTHORIZATION

I may revoke this authorization in writing. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its' purpose was to obtain insurance. I may revoke this authorization by writing a letter and mailing it certified mail, return receipt requested, to the Privacy Officer at the healthcare provider listed above.
Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.

This authorization is valid for one year for the release of information as indicated above. **Only records from this facility can legally be released.** Any records from other physicians must be obtained from them.

________________________________ ____
Patient Signature & Date Parent/Guardian Signature & Date

____
Witness Signature & Date

HIPAA PRIVACY NOTICE

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our Executive Director in person or by phone number given in the HIPAA Notice of Privacy Practices.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices. If the patient refuses to sign the notice, this practice is not obligated to treat the patient.

Print Name:_______________________________________ Date:________________

Signature____

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HIPAA Notice of Privacy Practices
Center for Speech and Language Pathology, LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by the Center for Speech and Language Pathology, LLC and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the Center for Speech and Language Pathology's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your healthcare with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for the treatment.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of speech pathology students, licensing, marketing and fund raising activities, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your therapist. We may also call you by name in the waiting room when your therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.
You may revoke this authorization at any time in writing, except to the extent that your physician or the physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following is a statement of your rights with respect to your protected health information.
You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.
You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. In the case of a child custody issue, we will need a legal documentation stating that no information is to be released to the person to whom you want the restriction to apply.
Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.
You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively.
You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.
Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

Center for Speech and Language Pathology, LLC Contact:

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