



New Patient Information

CHILD INFORMATION

Child's Full Name: _____ DOB ____/____/____

Home Address: _____

City _____ State _____ Zip _____

Sex: ____M ____F Primary language used in the home: _____

PARENT/GUARDIAN INFORMATION:

Parent/Guardian Name: _____ Relationship to Child: _____

Home Address (if different from child): _____

City _____ State _____ Zip _____

Primary Email: _____

Primary Phone Number: _____ Alt Phone Number: _____

Reason for visit: _____

Referring Physician: _____ Phone Number: _____

Primary Physician: _____ Phone Number: _____

Referral source: _____

Emergency Contact Information (other than parent/guardian):

Contact Name: _____ Phone Number: _____



INSURANCE INFORMATION

Primary Insurance Company: _____

Group # _____ Subscriber ID _____

Name of Policy Holder: _____

Policy Holders SSN: _____ DOB of Policy Holder: ____/____/____

Policy Holders Address (if different from child): _____

Relationship to child: _____ Employer: _____

Secondary Insurance Company: _____

Group # _____ and/or Subscriber # _____

Name of Policy Holder: _____

Policy Holders SSN: _____ DOB of Policy Holder: ____/____/____

Policy Holders Address (if different from child): _____

Relationship to child: _____ Employer: _____

It is your responsibility to inform us of any additional policies and/or changes to your insurance.

It is illegal to bill a secondary insurance first if there is a primary policy in place.

Family Information

Person completing this form: _____ Relationship to child: _____

Responsible party: _____ Responsible party SSN: _____

Guardian's Name: _____ Age: _____ Occupation: _____

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People living in the home (please use back if more room is needed):

Name: _____ Age: _____ Relationship: _____

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Name: _____ Age: _____ Relationship: _____

Speech and Language

What language is spoken primarily in the home? _____

What language does your child primarily speak? _____

Describe your child's current speech/language concerns: _____

Age of first spoken word: _____ Age of first sentences: _____

Describe your child's communication at the present time (Please check all that apply):

____ Grunts	____ Copies what you say	____ Screams
____ Points	____ Single words	____ Stutters
____ Gestures	____ Two-word phrases	____ Too soft/quiet
____ Takes you to object	____ Longer sentences	____ Too loud
____ Copies what you do	____ Unclear speech	____ Nonverbal



Approximately how many words does your child use? _____

Does your child use 2+ words together? ____ Yes ____ No Examples: _____

Does your child seem to understand you? ____ Yes ____ No

How does your child express his/her wants and needs? _____

Does your child ask questions? ____ Yes ____ No

Does your child follow simple commands (i.e. stop)? ____ Yes ____ No

Does your child follow 2-step commands (i.e. pick up your socks and come here)? ____ Yes ____ No

Describe any family history of speech and/or language disorders/concerns: _____

Has your child received any developmental evaluations prior to today? If "Yes" explain. ____ Yes ____ No

Please list any previous therapeutic services your child has received:

Service: _____ Duration: _____ Targeting (Goals): _____

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How successful do you feel previous therapies were for your child? Please explain:

School/Daycare: _____ Grade: _____

Is your child enrolled in any special education classes? ____ Yes ____ No

Is your child receiving speech and language services at school? ____ Yes ____ No

Most difficult school subject: _____ Favorite school subject: _____

Comments about school: _____

Self-Help and Development

At what age did the following first occur?

_____ Sat up alone _____ Crawled _____ Self-Feeding

_____ Walked unaided _____ Potty trained _____ Self-Dressing

Does your child demonstrate any sensory concerns? ____ Yes ____ No

If yes, please describe _____

Does your child appear clumsy during daily tasks? ____ Yes ____ No

Has your child received any intervention or therapy for motor development? ____ Yes ____ No

Do you have any other developmental concerns? ____ Yes ____ No If yes, what? _____

Does your child make eye contact? ____ Yes ____ No

Prenatal/Birth History

Weeks gestation: _____ Birth weight: _____ Full Term? ____ Yes ____ No

Did your child experience any of the following conditions immediately following birth?

____ Breathing difficulties ____ Oxygen needed ____ Feeding problems

____ Jaundice ____ Seizures ____ Sucking/swallowing difficulties

____ Bleeding ____ Infections

Were there any complications during pregnancy? ____ Yes ____ No If Yes, explain _____

List any surgeries that were required: _____



General Medical History

Please check all that apply:

- | | | |
|---|--|---|
| ☐ High fever | ☐ Other injuries | ☐ Eating/swallowing difficulties |
| ☐ Ear infections | ☐ Hospitalizations | ☐ Glasses |
| ☐ Seizures | ☐ Illnesses | ☐ Hearing problems |
| ☐ Asthma | ☐ Operations | ☐ Wears a hearing aid |
| ☐ Frequent colds | ☐ Medications | ☐ Behavioral problem |
| ☐ Allergies | ☐ Diagnosed with ADD/ADHD | |
| ☐ Head injuries | | |

Please explain the items checked: _____

Has your child ever been hospitalized? ☐ Yes ☐ No If yes, explain _____

Please list any medications your child is currently taking. Include dosage per day: _____

Has your child had any difficulties with his/her tonsils or adenoids? ☐ Yes ☐ No If yes, explain _____

Does your child: Drool ☐ Yes ☐ No Have an open mouth posture ☐ Yes ☐ No

If there a history of high fevers or seizures? ☐ Yes ☐ No

Is your child visually impaired? ☐ Yes ☐ No Is your child hearing impaired? ☐ Yes ☐ No

When was your child's last hearing assessment? _____ Results? ☐ Pass ☐ Fail

Does your child have a diagnosis of food, medication, or environmental allergies? ☐ Yes ☐ No

If yes, please list with reaction: _____



Is your child allergic to latex? ____ Yes ____ No

Do you have any concerns regarding issues related to feeding and/or swallowing? ____ Yes ____ No

If yes, please explain: _____

Does your child use any adaptive equipment? ____ Yes ____ No If Yes, please explain: _____

Preferences

Please indicate your child's favorite item in each of the categories:

Food: _____

Drink: _____

Toy: _____

Movie: _____

TV Show: _____

Activity: _____

What activities does your family enjoy doing together? _____

Describe your child's strengths: _____

Additional information, comments, or questions: _____



Cancellation & Clinic Policies

It is very important for your child to attend their regularly scheduled appointments. These scheduled appointments are part of a recommended treatment plan aimed at improving health, function, and the overall quality of life of your child. Without regular and consistent attendance, the benefits of therapy will be limited.

Please initial each section below:

_____ I understand that I must notify My Turn Pediatric Speech Therapy of all appointment cancellations 24 hours in advance. This will allow My Turn Pediatric Speech Therapy to service other children in need. My account will be assessed a \$50 fee per provider for missed appointments with less than 24 hours notice. This is mandatory fee that is your responsibility and non-negotiable.

_____ If you are late for an appointment, the therapy session will still end at the originally scheduled time unless accommodations can be made. If not, you will still be responsible for the full fee.

_____ Due to national insurance changes with CPT billing codes for therapy services, starting January 1st, 2027, you will be responsible for a \$35 late fee per provider if you arrive for your appointment more than seven minutes late. For all Medicaid eligible recipients late arrivals will result in dismissal of services.

_____ Late fees are due at the time of service.

_____ Fees for missed appointments and late cancellations cannot be charged to insurance.

_____ An 80% attendance rate per three-month period during the current plan of care is required. If you accrue more than two no shows during your time of care, your child will be dismissed from our clinic.

_____ Therapy sessions are 1:1 with the child and therapist. Parents are required to separate.

_____ My Turn staff requires parents to complete any bodily fluid clean up.

_____ You are required to remain within eye sight of the clinic at all times in case your therapist or child requires your assistance.

My Turn Pediatric Speech Therapy holds the right to discontinue therapy services if the above policies are not maintained.

Child's name: _____

Responsible party: _____ Relationship: _____

Signature: _____ Date: _____



Patient Financial Policy

We would like to thank you for choosing My Turn Pediatric Speech Therapy as your health care provider. By signing this agreement, you are agreeing to pay for all services provided to you and on your behalf by My Turn Pediatric Speech Therapy. Please read the following carefully and ask if you have any questions.

Payment options if you have insurance: Insurance is a contract between you and your medical carrier and we are not a party to this contract. We will file insurance claims as a courtesy to our patients. We cannot negotiate issues related to deductibles, co-payments, covered charges, or eligibility. Co-pays are due at time of service. If we have not received payment from your insurance carrier within 60 days, you will be responsible for services rendered. In the event that we receive payment from your insurance carrier after you have paid, we will return the payment directly to you. We will estimate what your insurance carrier will pay, however your insurance company makes the final determination of your eligibility and benefits. If your carrier is not contracted with us, you agree to pay any portion of the charges not covered including those above the usual and customary allowance.

My Turn Pediatric Speech Therapy will charge the credit card placed on file for any treatment/evaluation fees, no show/cancellations fees, and any billing amounts not covered by commercial insurances per our financial agreement.

Records for personal use and/or personal insurance filing can be purchased at the rate of: Evaluations: \$5.00 and Daily Notes: \$2.00 each.

Payment options if you have no insurance: Payment is due at time of service. You may pay by cash, check, or credit card. We offer a 20% discount for full payment at time of service.

Referrals and Pre-authorizations: Your insurance carrier may require a referral from your physician and/or a pre-authorization for us to provide services. It is your responsibility to obtain a referral or preauthorization if required by your insurance company. Please note that failure to obtain a referral and/or preauthorization may result in a decreased or no payment from your insurance company, and the balance will be your responsibility. We will work with you and your insurance company to assist with obtaining referrals and authorizations.

Returned Checks: There is a fee of \$35.00 on all returned checks not honored by the bank.

Past Due Accounts: Accounts 30 days past due will be assessed a 5% finance charge monthly. If your account becomes past due, we will take steps to collect this debt. If we must refer your account to a collection agency, you agree to pay all the collection costs incurred, including reasonable lawyer fees and court costs as necessary.

By signing below, you acknowledge that you have read and understand the financial policies described above.

Child's name: _____

Responsible party: _____ Relationship: _____

Signature: _____ Date: _____



Acknowledgement That You Have Received Our HIPAA Privacy Notice

My Turn Pediatric Speech Therapy is 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 My Turn Pediatric Speech Therapy'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 My Turn Pediatric Speech Therapy cannot disclose my health information other than as specified in the notice.

____ I understand that My Turn Pediatric Speech Therapy's 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 Client

Date

Signature of Parent or Legal Representative

Relationship to Client