MY TURN
PEDIATRIC SPEECH THERAPY, LLC

New Patient Information

CHILD INFORMATION

Child's Full Name: _____ DOB____/_____/_____

Sex: ___M ___F Student Status: ____Full-Time ____Part-Time _____None/Other

Home Address: _____

City_____ State_____ Zip _____

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:

Contact Name: _____ Phone Number: _____

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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: _____

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Family Information

Person completing this form: _____ Relationship to child: _____

Father's Name: _____ Father's Age: _____ Occupation: _____

Mother's Name: _____ Mother's Age: _____ Occupation: _____

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

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

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? _____

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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): _____

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

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

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: _____

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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: _____

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General Medical History

Please check all that apply:

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

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: _____

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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: _____

_____

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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, or the overall therapy will take longer.

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 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.

_____ 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.

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

_____ You are required to remain within eye sight of the clinic at all times.

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: _____

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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.

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: _____

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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

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