Accurate Speech Inc.
20800 Westgate Mall Suite 510
Fairview Park OH, 44126
440-895-1309
accuratespeech@gmail.com

Accurate Speech Intake Form

The information provided on this form will assist in planning and providing the appropriate services for the child. All information will be a part of the child's record and will be confidential. Information may be stated in the report unless requested that it be kept private. Thank you for your help.

Today's Date: _____
Person completing this form: _____ Relationship to child: _____
Who referred you to Accurate Speech Inc.? _____
Reason for visit: _____

General Information:

Child's name: _____ Name usually called: _____
Birth date: _____ Age: _____ Sex: _____
Physician (Name & Address): _____
_____
List any allergies/dietary restrictions your child has: _____
_____

Address: _____
City: _____ Zip Code: _____
Phone: _____ Phone: _____

Emergency Contact Name: _____ Relationship: _____
Emergency Contact Phone: _____

Insurance:

Guarantor: _____ Relationship to child: _____
Social security number: _____ Date of birth: _____
Phone number: _____
Name of Insurance Company: _____
Member ID: _____ Group number: _____
Address of guarantor: _____
_____

I authorize release of any information concerning my (my child's) health care, advice & treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also, hereby authorize payment of insurance benefits directly to Accurate Speech Inc.

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Speech & Language History:

Describe the current speech/language problem: _____
_____

Age child babbled____ Age child spoke first words____ Age child used sentences _____

How does your child get his/her needs/wants met? _____
_____

Please give an estimate of how many words are in your child's vocabulary:
Receptive Language (words understood) ____ Expressive Language (words spoken) _____

How much of your child's speech do you understand?
☐ 10% or less ☐24-54% ☐55-74% ☐75%-100%

How much of your child's speech do other people understand?
☐10% or less ☐24-54% ☐55-74% ☐75%-100%

Does your child demonstrate frustration when he/she is not understood? (If yes, please explain):
_____
_____

Is your child able to follow directions? (1 and 2 step): _____

Describe your child's primary mode of communication (i.e. babbling, gestures, single-words, etc...):
_____
_____

Has your child's speech, language, and hearing previously been evaluated? If yes, please explain where and why?
_____
_____

If your child receives (or received) speech/language services somewhere else, please explain goals that were addressed:
_____
_____
_____

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Medical History

Does your child have a medical diagnosis? If yes, please explain: _____
_____

Has your child been hospitalized? If yes, please explain when and the reason: _____
_____

Does your child have difficulty hearing? _____
Does your child experience frequent middle ear infections? _____
Does your child have middle ear tubes? If yes, state when they were placed:
_____

Has your child's hearing been evaluated? If so, when and what were the results? _____
_____

Has your child received any other services (i.e. Physical Therapy, Occupational Therapy, Special Education, Early Intervention, etc.)? If yes, please explain the services received and goals addressed.
_____
_____
_____
_____

Any other pertinent medical history: _____
_____

Family History:

Fathers Name: _____ Mother's Name: _____
Father's Education: _____ Mother's Education: _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Other's living in child's home:
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____

Are there any family members or relatives who have or had any speech, language, or hearing issues or therapy? If yes, please explain:
_____
_____

Are there any family members or relative who have or had received any kind of Special Education Services? If yes, please explain: _____
_____

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Developmental History:
Please describe any significant prenatal or birth history:

_____
_____
_____

Please list any motor development concerns you have (i.e. gross motor, oral motor, fine motor, fear of heights/movements, motor planning, etc.):

_____
_____

Please list any concerns with feeding/eating or allergies:

_____

Please describe any other developmental concerns you may have had about your child:

_____
_____

Behavior/Social History:
Please check all that apply to your child:

- ☐ Is social and engaging
- ☐ Makes good eye-contact
- ☐ Listens well
- ☐ Is easy going
- ☐ Takes turns with peers
- ☐ Prefers to play alone
- ☐ Is very busy and active
- ☐ Extremely sensitive to criticism
- ☐ Is aggressive
- ☐ Is well behaved
- ☐ Follows directions well
- ☐ Does well with change
- ☐ Maintains topic
- ☐ Difficulty listening
- ☐ Poor coping skills
- ☐ Has tantrums
- ☐ Is oppositional
- ☐ Pays attention
- ☐ Plays well with others
- ☐ Understands safety
- ☐ Difficulty with transitions
- ☐ Difficulty paying attention
- ☐ Unable to self-calm

Please list behavioral or social concerns:

_____
_____

What are some of your child's favorite toys/interests?

_____
_____

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Academic History:

Name of the school currently attending: _____ Current grade: _____

Name of schools previously attended: _____

Please check all that apply to your child:

- ☐ Does well in school
- ☐ Challenged by school
- ☐ Is in a self-contained classroom
- ☐ Receives school-based services
- ☐ Is on an IEP

If your child received any pull-out services or is in a self-contained classroom, please describe the services and/or classroom setting.

_____

_____

List any academic concerns you have:

_____

_____

List any specific teacher concerns:

_____

_____

Evaluation/Therapy Services:

What are your primary areas of concerns of your child's speech/language?

_____

_____

What are your goals for therapy?

_____

_____

_____

Please list any previous therapy evaluations completed and recommendations?

_____

_____

_____

Please list and previous psychological or neurophysiological evaluations completed and recommendations: _____

_____

_____

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POLICY STATEMENT

1. Therapy bills will be issued the first week of each month. Payment is due by the 20th of each month. Please be timely with payments. A late fee of $25.00 will be applied to all past due invoices. **Initial here** _____.

2. Families have the option of making payment using their VISA, MasterCard or American Express.

3. Regular attendance is essential for your child's growth in therapy. Please refer to the attached Cancellation Policy.
   Initial here to indicate you have received our Cancellation Policy _____.

4. The waiting area is supplied with toys and books for your child in therapy as well as for any siblings. Please keep the waiting area reasonably quiet and assist the children with toy cleanup.

5. We make every attempt to establish good working relationships with your child's school and pediatrician. If you would like our attendance at a staffing for your child, please make your request at least two weeks in advance so that an updated status of review can be prepared. Attendance at such meetings is charged the same rate as hourly, therapy-based treatment sessions and is not covered by insurance.

6. Progress reports with treatment plan and goals are written upon request, or as dictated by your insurance company. Families are billed for one hour of service for these documents. Evaluation and re-evaluations are billed at the hourly rate for test administration, test scoring and interpretation, and report writing.

7. Complaints and concerns: Should you, as your child's parent/guardian, have a grievance/complaint that you wish to discuss, please contact the clinical director by phone or email. You will receive a response within 48 business hours of message being sent.

I have read the above policy and agree to abide by it.
I grant permission for treatment of my child.

_____ _____

Parent's Signature and Date Print Child's Name

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CANCELLATION and "NO SHOW" POLICY

Regular attendance is essential for your child's growth in therapy. However, there are times when then cancellation of an appointment is necessary.

Everyone's time is valuable, including ours. The following is Accurate Speech Inc.'s cancellation policy.

- Cancellations made with less than a 24-hour notice, will be charged at 100% for the therapy session fee.
- **All cancellations will be billed directly to the client; no cancellations or 'no-shows' will go through your insurance company.**
- **Our voice mail is available 24 hours a day. You can call at any time during the day or night to notify Accurate Speech Inc. that you need to cancel your child's session. You can also email us at, accuratespeech@gmail.com, at any time to cancel your child's therapy session.**

By signing below, I acknowledge receipt of cancellation policy and agree to the terms stipulated above.

_____ _____

Parent's Signature and Date Print Child's Name

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Insurance Policy Statement

I would like Accurate Speech Inc. to file my insurance claims and agree to provide all the pertinent documentation, (ie a signed HCFA 1500 Form; a completed and signed Payment Policy Statement; a copy of your insurance card (front and back); and the written referral from your physician).

Please initial next to the statement that reflects accurate information you have received directly from your insurance company.

_____ Pre-Authorization from my insurance company, as listed below, is necessary for Initial Evaluation;
_____ Pre-Authorization from my insurance company, as listed below, is necessary for Therapy.
_____ Pre-Authorization is NOT necessary for Initial Evaluation.
_____ Pre-Authorization is NOT necessary for Therapy.

This information must be provided in full for our office to process claims.

Insurance Company Name: _____
Identification Number: _____
Group Number: _____
Referring Physician Name _____
Physician's complete _____
Address _____
Physician's Phone/Fax # _____

If my insurance benefits change, it is my responsibility to notify Accurate Speech Inc. immediately. If I fail to do so, I am obligated to cover any costs or fees that insurance denies. If my insurance company denies any claims, I understand that I will be responsible for paying the amount that is owed.

Because your insurance company notifies you independently, once your insurance company has determined their coverage, or denial of coverage, you are obligated to make payment in full of the balance due to Accurate Speech Inc. within 20 days of your insurance company's notification. If payment is not received within 20 days, Accurate Speech Inc. will assess a late fee in the amount of $25.00. If a personal check is returned because of insufficient funds, Accurate Speech Inc. will assess a fee of $25.00.

I have read the above Payment Policy Statement and my signature below is confirmation that I understand I am ultimately responsible for full payment of services provided by the professionals at Accurate Speech Inc.. Accurate Speech Inc. does not guarantee that any services provided by its professionals, will be automatically covered by your insurance carrier. I understand that this contract is with me, the client, not my insurance carrier.

_____ _____
Date **Signature / Printed Name**

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Permission to Videotape and Photograph

Permission is granted for my child _____ to be videotaped and photographed by Accurate Speech Inc. for these reasons:

- Pre-test and post-test observations by my child's SLP and other SLPs on staff at Accurate Speech Inc.
- For direct review and training with parent
- As feedback with my child directly as part of his/her therapy program
- As feedback with my child and other children as part of his/her pragmatic/social language skills training

_____
Signature

_____
Date

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this information carefully.

Accurate Speech Inc. and staff understand that medical information about your health is personal and we are committed to protect your medical information. According to Health Insurance Portability and Accountability Act of 1996 (**HIPPA)**, your Protected Health Information **(PHI)** can and will be used only for the following purposes:

- **Treatment** means providing, coordinating, and follow up on your treatment plan among the Accurate Speech Inc. providers that may be involved in your treatment plan. An example would be the speech assessment session.
- **Payment** means activities to obtain reimbursement for rendered services, conforming coverage, authorization, billing, and utilization review. An example would be sending a bill for your visit to your insurance company.
- **Healthcare Operations** means the business part of running our practice. It includes performing internal quality assessment, improving activities, conducting cost analysis, and customer services. An example would be a cost analysis review.

Under the following circumstances HIPAA allows PHI to be released without authorization: *Emergency, Identification of deceases or cause of death, Public Health issue, Requirement for national defense and security, judicial & administrative proceedings, and requirement under law enforcement.* ***Any other uses and disclosures will be made with you written authorization.***

Under HIPAA you have the following rights with regard to your PHI that you can exercise by presenting a written request to our office:

- The right to request restrictions on certain uses and disclosures including those disclosures to family members
- The right to inspect and copy medical records
- The right to amend your PHI
- The right to receive an accounting of disclosures
- The right to obtain copy of this notice

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Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have the right of privacy regarding my Protected Health Information (PHI). I understand that information can and will be used to complete Treatment, Payment, and healthcare Operation (TPO).

- Treatment and follow up among the multiple healthcare providers who may be involved in that treatment, directly and indirectly.
- Obtain payment from third-party payers.
- Healthcare operations such as quality assessment and therapist certification.

I have received, read, and understand the notice of privacy practices. Containing a complete description and uses of my PHI. I understand that Accurate Speech Inc. has the right to change its Notice of Privacy Practices form time to time and that I may contact the office to obtain a current copy of the privacy notice.
I understand that I may request in writing to restrict Accurate Speech Inc. how my PHI is used and disclosed to carry out treatment, payment, and healthcare operations. I also understand that the office is not required to agree with my requested restrictions, but upon agreement, than Accurate Speech Inc. will comply with such restrictions.

_____ _____
Print client name (parent/guardian) Relationship

_____ _____
Signature of client (parent/guardian) Date

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