Patient Information/Consent Form

Patient Name:_____ Gender: male female DOB:_____
Address:_____

Parent/Guardian 1 Name:_____ DOB:_____ SS#:_____
Cell #:_____ Home #:_____ Work:_____
Employer:_____ Email:_____

Parent/ Guardian 2 Name:_____ DOB:_____ SS#:_____
Cell #:_____ Home #:_____ Work:_____
Employer:_____ Email:_____

Primary Care Physician

Name of Practice/Doctor:_____ Phone #:_____
Fax:_____ Address:_____
Diagnosis or reason for referral:_____

Primary Insurance

Patient Name:_____ DOB:_____
Insured's Name:_____ Relationship:_____ DOB:_____
Insurance Company:_____
Customer Service/Provider #:_____
Claims Address:_____
Member/Subscriber ID #:_____ Group ID:_____

Secondary Insurance

Patient Name:_____ DOB:_____
Insured's Name:_____ Relationship:_____ DOB:_____
Insurance Company:_____
Customer Service/Provider #:_____
Claims Address:_____
Member/Subscriber ID #:_____ Group ID:_____

☐ I do not have insurance or I do not wish to bill my insurance for services rendered. I understand that **Kidspeech, Inc.** requires that all payments for services rendered be paid in full at the time of service. It is the responsibility of the parent/guardian to notify **Kidspeech, Inc.** of any changes.

I hereby confirm that all information provided on this form is true to the best of my knowledge.

_____ _____ _____
Parent/Guardian (print name) Parent/Guardian signature Date

It is important for authorization and billing purposes that you provide **Kidspeech, Inc**. with all information about the services your child has received or is currently receiving.

Does your child receive Speech-Language, Occupational or Physical Therapy services with the Public School System? **Yes** **No** If yes, specify county:_____ Frequency:_____

To ensure accurate services are provided and that your child receives the best care, **Kidspeech Inc. MUST** have a copy of your child's current IEP before services are provided.

Most insurance companies require pre-certification or authorization to be in place prior to services being rendered. If there is another authorization in place with a different provider, your insurance company will not approve services with **Kidspeech, Inc**. Therefore, you will be responsible for any charges denied by your insurance company for this reason.

Other than the school system comma, is your child receiving Speech-Language, Occupational, or Physical Therapy services with any other company? **Yes** **No** If Yes, which company:_____

_____ I understand that **Kidspeech, Inc**. will verify my benefits with my insurance company as a courtesy . However, the verification of benefits **is not** a guarantee of payment. Claim payment is determined at the time services are rendered and eligibility, exclusions, or provisions on your plan may affect payment. It is also recommended that you call your insurance company to be aware of your benefits.

_____ I understand that each Medicaid program has different authorization requirements. It is very important that you notify our office of any changes. This will ensure that your child receives continuation of care and that we obtain authorizations as required by your policy, so that you will not be responsible for these charges.

_____ I understand that insured/parent/guardian listed above is fully responsible for any balance due, non-covered services, and/or denied claims for any reason.

_____ I authorize **Kidspeech, Inc**. to release any medical records or other information necessary to process claims pertaining to my treatment.

_____ I authorize payment of medical benefits to **Kidspeech, Inc.** I also understand that it is my responsibility to immediately inform this office of any insurance or address changes.

_____ I have been notified of all HIPPA regulations and I have received and read a copy of the Privacy Practices regulations implemented by **Kidspeech, Inc.**

_____ I understand that I am making a commitment based on recommendations made by my clinician for my child. It is my responsibility to make sure that my child is at each scheduled appointment and to implement the home program provided by my child's clinician.

_____My clinician will share information regarding progress at the end of the session; typically, a five minute time slot during the regular scheduled therapy session.

_____I understand that if I am late for a scheduled session that my clinician will only see my child for the remaining time and will not run into the next scheduled appointment.

I hereby confirm that all the information provided on this form is true to the best of my knowledge. I also understand that services will be provided as recommended by my Physician and the Speech-Language Pathologist.

_____ _____ _____

Parent/Guardian (print name) Parent/Guardian Signature Date

Background Information

Patient Name:_____ Parent/Guardian:_____

DOB:_____ Gender: male female Home Phone #:_____

PCP (referring physician):_____

Current diagnosis:_____

Patient lives with (check one): ___ Birth Parents ___Adoptive Parents ___ Foster Parents ___One Parent

Is there a language other than English spoken in the home? ___Yes ___No Language:_____

Does the child speak the language? ___Yes ___No

Does the child understand the language? ___Yes ___No

Does your child attend school or daycare; if so, where? _____

Does your child have an Individualized Education Plan (IEP)? ___Yes ___No

If yes, WE WILL NEED A COPY OF THE MOST CURRENT COPY OF THE CHILD'S IEP.

Family History

Please indicate if any relatives of the client are/have been diagnosed with the following conditions:

	Mental/Intellectual Disability		Speech/Language Delay
	Developmental Delay		Reading Difficulties
	Cleft Lip/Palate		Learning Disability
	Autism/PDD		Attention Deficits
	Hearing Loss		Other Birth Defects
	Social Difficulties		

What is your primary concern with your child's speech and language skills?_____

_____

Birth History

Pregnancy: _____Full-Term: _____ Premature: (_____ weeks gestation)

Birth History: _____Unremarkable: _____ Please explain any complications: _____

_____

Did your child pass the infant hearing screening? ___Yes ___No

NICU Stay: _____Yes _____No If yes, please explain:_____

Did your child require oxygen? _____ Yes _____No How Long?_____

Was your child intubated? _____Yes _____No How long?_____

Did your child leave the hospital with his/her mother? _____Yes _____No

Medical History

Has your child ever been diagnosed with any of the following?

	Adenoidectomy		Head injury		Sleeping difficulties
	Allergies		Hearing loss		Surgery
	Breathing Difficulties		High fevers		Thumb/finger sucking
	Colds		Meningitis		Tonsillectomy
	Ear infections		Mouth Breathing		Vision Difficulties
	Encephalitis		Seizures		

Is your child currently (or recently) under a physician's care? ___ Yes ___No

Please list any medication your child takes regularly:_____

Does your child have any food or medical allergies? ___Yes ___No

Please list:_____

Please tell the approximate age your child achieved the following developmental milestones:

_____ Crawl _____ Sat up _____Stood alone

_____ Walked _____ Fed self _____ Dressed self

_____ Toilet trained _____ Single words _____ Combined words

Current Feeding

Does your child have any of the following symptoms when eating or drinking? (Check all that apply)

Yes	No		Yes	No		Yes	No	
		Gagging/Coughing during or after meals			Tooth brushing intolerance			Difficulty progressing to table food
		Vomiting			Choking			Refusal to eat
		Limited variety of foods			Difficulty swallowing			Self-feeding
		Slow weight gain			Limited volume intake			Holding food in mouth
		Difficulty chewing			Overstuffing mouth			

Has your child received or does he/she currently receive therapy services (OT, PT, ABA, ST, etc.)?

Therapy	**Frequency**	**Location**	**Treating Clinician**

Language History

In which of the following areas does your child seem to have difficulties? Check all that apply.

	Understanding others		Using sentences		Voice difficulties
	Saying specific sounds		Stuttering		Learning new concepts
	Being understood		Memory skills		Social interactions with peers
	Following directions		Asking questions		Eye contact

Other difficulties:_____

_____

_____

How many words in your child's expressive vocabulary: ___0-5 ___10-20 ___25-50 ___50+

Your child currently communicates using: ___ gestures ___ sounds (vowels, grunting) ___words (ball, cup, shoe) ___phrases (2-4 utterances) ___sentences longer than 4 words

Other information about your child's communication:_____

_____

_____

Is your child difficult to understand? ____ to you ____to an unfamiliar listener
Can your child blow bubbles? ___Yes ___No

Sensory Integration

Does your child have sensitivities to:	**Yes**	**No**
Tags/Clothing		
Loud Noises		
Walking in sand/grass		
Getting his/her hands dirty		
Different textures in food		
Transitioning to new activities		
Brushing hair/teeth		

Behavioral Characteristics

Please check all that apply:

___ Cooperative	___ Restless	___ Attentive	___ Poor Eye Contact
___ Easily Distracted	___ Short Attention	___ Withdrawn	___ Plays Alone
___ Aggressive	___ Easily Frustrated	___ Stubborn	___ Friendly
___ Willing to Try New things		___ Impulsive	___ Self Calms