harbor speech PATHOLOGY
hope, healing and recovery

Harbor Speech Pathology
Pediatric Admission Form

Date of First Appointment: _____
Diagnosis Codes: _____ Treatment Codes: _____
Please fill out ALL spaces below to the best of your knowledge—Thank you

Patient Information:

Childs Name:_____ Date of Birth:_____

Mother's Name:_____ Occupation:_____

Father's Name:_____ Occupation:_____

Guardian's Name:_____ Occupation:_____

Address:_____ City/State/Zip:_____

Home Phone:_____ Work Phone:_____ Cell:_____

E-Mail:_____

Referred By:_____

Reason for Referral:_____

Child's Physician:_____

Phone:_____ Location:_____

Other specialists who have worked with this child: _____

Medical Insurance:

Primary Insurance: _____ Phone: _____

Subscriber Name: _____ Date of Birth: _____

ID Number: _____ Group Number: _____

Secondary Insurance: _____ Phone: _____

Subscriber Name: _____ Date of Birth: _____

ID Number: _____ Group Number: _____

Harbor Speech Pathology
5202 Olympic Drive NW #100, Gig Harbor, WA 98335
Phone: (253) 851-0007 Fax: (253) 514-8261 E-Mail: harborspeech@live.com

Welcome to Harbor Speech Pathology! We are happy to assist you with any questions you may have. Please take a few moments to read the following information.

Consultation: We are happy to meet with prospective patients for a free, fifteen-minute consultation to answer any questions you or your child may have.

Insurance: We accept most major insurance plans. As a courtesy to you, we will call your insurance company to verify your coverage for therapy in our office. Benefits quoted by an insurance representative are not a guarantee of payment and at times, can be quoted incorrectly. We encourage you to call your insurance company prior to your first appointment to verify that your child is covered for therapy in our office.

Evaluation: Depending on age and abilities, we spend between 30 minutes and 1 hour with patients for the first appointment. The evaluation generally involves information gathering as well as time for the therapist to get to know your child and their unique situation. Most insurance companies cover the cost of a speech evaluation regardless of if they cover the subsequent therapy visits. Occasionally, there are co-pays or uncovered portions of an appointment. Please understand that any unpaid balance is your responsibility.

Treatment: We are able to accommodate our patients with appointments times from 9:00 a.m. to 6:00 p.m., Monday through Friday. We do our best to find a regular appointment time (weekly or bi-weekly, if desired) for each patient with one of our four Speech-Language Pathologists.

Cost of Supplies: Occasionally, with your consent, we will order supplies to be used in your therapy sessions and at home. In the case that your insurance company does not cover these expenses, you will be responsible for the bill.

Financial Policy: Insurance co-pays are due at time of service. It is the policy of our office to bill all claims to your insurance company as a courtesy to you. The responsibility for payment of your child's account remains with you at all times, including closed or rejected Labor and Industries claims. **Your insurance policy is a contract between you and the insurance company.** In many instances your insurance will cover only a portion of the charges. You should be aware that you are responsible for the balance of your bill. If your claim is denied, you will be responsible for the entire charge. If no insurance is available, private payment is due at the time of service. We accept personal checks, all major credit cards, and cash payments.

Referrals/Prescriptions: Some insurance companies and insurance plans require a referral for Speech Therapy. If your insurance requires a referral/prescription, it is your responsibility to obtain one from your child's pediatrician and to make sure that we have it at the time of services.

I HEREBY AGREE TO FULL RESPONSIBILITY FOR ALL EXPENSES INCURRED BY OR IN THE ACCOUNT OF _____. I AUTHORIZE MY INSURANCE COMPANY TO PAY DIRECTLY TO HARBOR SPEECH PATHOLOGY FOR SERVICES RENDERED. I AGREE THAT I WILL PAY ANY REMAINING BALANCE NO LATER THAN 30 DAYS FOLLOWING THE INSURANCE PAYMENT.

_____ _____

Signature of patient or authorized representative Date

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Cancellation Policy

Dear Valued Patient,
We realize that coming to us for treatment requires a substantial investment in time on your part. We have adequate staff on hand to allow 30-60 minutes for each appointment. This does mean that if you cancel an appointment without adequate notice, we may not be able to fill your appointment time. If you arrive late for your appointment you will miss part of your treatment for that day.

We charge a fee of {$50.00} if an appointment is cancelled without 24-hour notice.
This charge is **NOT** covered by insurance and will be your direct responsibility.
This is much than the value of an appointment. It is not intended to be punitive but rather to partly offset the cost of paying the staff on hand for the time set aside for you.

Thank you for your understanding with our policy as we do our best to provide you with quality service.

Sincerely,

Channa Beckman, M.A., CCC-SLP / CBIS
Harbor Speech Pathology

I have read and understand Harbor Speech Pathology's cancellation policy.

_____
Printed Name

_____ _____
Signature **Date**

CONSENT FOR DISCLOSURE
WRITTEN AND VERBAL COMMUNICATIONS

I, _____, hereby authorize and request Harbor Speech Pathology or its representatives to:

( ) Release information to ( ) Obtain information from ( ) Exchange information with the following individual(s):

_____

_____

_____

_____

Regarding: _____ Date of Birth: _____

INFORMATION TO BE RELEASED:	YES	NO
Progress reports	_____	_____
Evaluations of treatment participation	_____	_____
Medical history/Social history	_____	_____
Psychological/Psychiatric testing, evaluation and reports	_____	_____
Other (specify) _____	_____	_____

_____

I understand that my records are protected under the Federal (42CFR) and State (RCW 71.05.390) confidentiality Law and Regulations. I also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it, and that, in any event, this consent expires automatically as specified below or in 90 days without such specification. This information released may be obtained via mail, telephone, fax, or in person.

Specification of the date, event, or condition upon which this consent expires: _____

_____ _____

PATIENT/ GUARDIAN SIGNIFICANT DATE

_____ _____

WITNESS DATE

Pre-School / School Aged Speech History Form

General Patient Information

Childs Name:_____ Date of Birth:_____

Name of person completing the form: _____ Date: _____

Pediatrician: _____ Phone Number: _____

Last seen by pediatrician: _____ Next Doctor Appointment: _____

Other specialists who have worked with this child : _____

_____

Please list those living in the home (relationship to patient: _____

_____

Please list principle concern in seeking this evaluation: _____

Health/Developmental History

Length of Pregnancy: _____ Birth Weight: _____

List medications taken during pregnancy: _____

Please answer YES or NO to the following and give details if YES:	YES	NO
Any illnesses, injuries or complications during the pregnancy/delivery?	☐	☐
Did this child require any special attention during his or her stay in the hospital?	☐	☐
Did the pediatrician have any special concerns during their first year?	☐	☐
Is this child taking any medications?	☐	☐
Has hearing been tested? If so, please indicate results below.	☐	☐
Have P.E. Tubes been placed? If so, by whom and when?	☐	☐
Is there a family history of speech, language or learning problems?	☐	☐
Has vision been tested? If so, please include results below.	☐	☐

Details: _____

Please describe history of ear infections (number, who diagnosed, treatment): _____

_____

Please describe any illnesses this child has experienced (dates & treatment): _____

_____

Please describe any injuries or accidents this child has experienced (dates & treatment): _____

_____

Does this child have a history of problems with chewing, feeding or swallowing? (describe) _____

_____

Please note at what age this child first: Smiled: _____ Sat alone: _____ Crawled: _____ Walked: _____

Spoke first word: _____ Drank from a cup: _____ Ate solid foods: _____ Was toilet trained: _____

Please check areas in which you have possible health or developmental concerns, and describe below:

- ☐ Hearing
- ☐ Vision
- ☐ Self-help skills
- ☐ Behavior
- ☐ Attention/concentration
- ☐ School achievement
- ☐ Physical health
- ☐ Diet/eating
- ☐ Play skills
- ☐ Eye contact
- ☐ Social interaction
- ☐ Balance and coordination
- ☐ Large motor skills (walking, sitting, jumping)
- ☐ Small motor skills (drawing, writing, object manipulation)
- ☐ Other: _____

Speech/Language History

What prompted your concerns regarding this child's speech and/or language development?

_____

What language is spoken in the home? _____

Is your child learning more than one language, does this child use and understand both? (please describe): _____

Expressive Language

At what age did this child: Babble: _____ Use single words: _____ Put two words together: _____
Use longer phrases or sentences: _____

How does this child communicate wants and needs? _____

Receptive Language/Comprehension

Do you have concerns about this child's ability to understand speech? (Please explain): _____

_____

_____

What type of directions, questions, or words can this child understand? (please give examples): _____

_____

_____

Articulation/Pronunciation

Please answer YES or No to the following and give details if YES:	YES	NO
Does this child have difficulty imitating simple sounds?	☐	☐
Does this child attempt to imitate words?	☐	☐
Do you have difficulty understanding this child's speech?	☐	☐
Do strangers have difficulty understanding this child's speech?	☐	☐
Does this child experience frustration when not understood by others?	☐	☐

Details: _____

_____

Fluency/Stuttering

When did dysfluency/stuttering first start or become noticeable? _____

_____

Please check behaviors observed with this child:

- ☐ Repeats part of words
- ☐ Repeats whole words
- ☐ Demonstrates tension in face or body
- ☐ Excessive or unusual eye blinking
- ☐ Excessive or unusual hand or body movements
- ☐ Repeats phrases
- ☐ Prolongs certain sounds
- ☐ Avoids eye contact
- ☐ Avoids certain words
- ☐ Unusual changes in loudness or pitch

Details: _____

_____

Voice Quality

Please describe this child's voice quality (e.g. clear, harsh, gravely): _____

_____

Has this child seen a specialist (ENT, etc.) for voice problems? Please list doctors and recommendations: _____

_____

_____

Is the voice quality consistent or does it vary? _____

When were the concerns first noted? _____

Did symptoms develop rapidly or slowly? _____

Is there any discomfort in the throat at any time? _____

General

Please provide any additional information that you feel may be relevant to the child's speech/language difficulty. Your comments and opinions are VERY important. _____

_____

_____

_____

_____

_____