199 New Road, Unit #38
Linwood, NJ 08221
Tel: 609-318-6614
Fax: 609-318-3053
info@speechbythebeachnj.com

Patient Identification

Patient's Last Name_____________________ First___________________
Gender_____________
DOB_________________ Age_________________
Home
Address____
City_____________________________________ State___________
Zip_____________________

Primary Care Physician_____________________________Phone#____________________

Primary Care Physician Address__________________________________

Additional Providers____

Contact Information

Do you want to communicate via text messaging? _____Yes _____No If you respond yes, confidential information will not be sent via text messaging.

Please provide names and the **BEST** possible phone number(s) and email. Be sure to notify us immediately of any changes. Please **CIRCLE** the email or phone that is the best way to reach you.

Parent(s)/Legal Guardian(s) Name(s)

Name__________________________________Email_________________________________

Phone #______________________________Phone#___________________________________

Social Security #______________________________

Name__________________________________Email_________________________________

Phone #______________________________Phone #________________________________

Social Security #______________________________

Emergency Contact Name: _______________________ Phone # _______________________

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Background Information:

Child lives with (check one):
Birth Parents_____ Foster Parents_____ One Parent(name)___________________
Adoptive Parents_____ Parent and Step-Parent_____ Other_____

Other children in the family:

Name	Age	Sex	Speech/Hearing Problems
1)______________	_____	_____	_____________________________________
2)______________	_____	_____	_____________________________________
3)______________	_____	_____	_____________________________________
4)______________	_____	_____	_____________________________________

What language(s) is spoken at home?

- Do you feel your child has difficulties with speech and/or language? Yes_____ No_____
    - If yes, please describe.

  ____
  ____
- Do you feel your child has a hearing problem? Yes_____ No_____
    - If yes, please describe.

  ____
  ____
- Has he/she ever had a speech-language evaluation/screening? Yes_____ No____
    - If yes, where and when?

  ____
    - Results?

  ____
- Has he/she ever had a hearing evaluation/screening? Yes_____ No____
    - If yes, where and when?____
    - Results?

  ____
- Has your child ever had speech therapy? Yes_____ No_____
    - If yes, where and when?

      ____

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    - What were the goals?
      ____
- Has your child received any other evaluation or therapy (physical therapy, counseling, occupational therapy, vision, etc.)? Yes____ No_____
    - If yes, please describe.

  ____
  ____
  ____
- Is your child aware of, or frustrated by, any speech/language difficulties?____
  ____
- What do you see as your child's most difficult problem in the home?
  ____
  ____
- What do you see as your child's most difficult problem in daycare/preschool/school?____
  ____
- Was there anything unusual about the pregnancy or birth? Yes_____ No____
    - If yes, please describe.

  ____
  ____
- How old was the mother when the child was born? _____________
- Was the mother sick during the pregnancy? Yes_____ No_____
    - If yes, please describe.

  ____
  ____
- How many months was the pregnancy?___________
- Did the child go home with his/her mother from the hospital? Yes_____ No____
- If child stayed at the hospital, please describe why and how long.
  ____
- Has your child had any of the following?

_____adenoidectomy
_____allergies
_____breathing difficulties
_____chicken pox
_____colds
_____ear infections/tubes
______mumps
_____encephalitis
_____flu
_____head injury
_____high fevers
_____measles
_____meningitis
_____vision problems
_____seizures
_____sinusitis
_____sleeping difficulties
_____thumb/finger sucking
_____tonsillectomy
_____tonsillitis

- Other serious injury/surgery:
  ____

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- Is your child currently (or recently) under the care of other medical professionals? Yes_____ No____
  - If yes,why? ____
- Please list any medications your child is currently taking: ____

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

__________ sat alone
__________ babbled
__________ put two words together
__________ walked
__________ drank from an open cup
__________ grasped crayon/pencil
__________ said first words
__________ spoke in short sentences
__________ toilet trained
__________ fed self with utensils

Does your child...
choke on food or liquids? Yes_____ No_____
currently put toys/objects in his/her mouth? Yes_____ No_____
brush his/her teeth and/or allow brushing? Yes_____ No_____

Does your child...
repeat sounds, words or phrases over and over? Yes_____ No_____
understand what you are saying? Yes_____ No_____
retrieve/point to common objects upon request (ball, cup, shoe)? Yes_____ No_____
follow simple directions ("Shut the door" or "Get your shoes")? Yes_____ No_____
follow 2 step directions("Get your shoes and give them to Mommy")? Yes_____No____
respond correctly to yes/no questions? Yes_____ No_____
respond correctly to who/what/where/when/why questions? Yes_____ No_____
respond to his/her name? Yes____No____
demonstrate appropriate eye contact while communicating? Yes____No____

Does your child currently communicate using...
_____body language (pointing, pulling, leading).
_____sounds (vowels, grunting).
_____words (book, cup, up).
_____2 to 4 word sentences.
_____sentences longer than four words.
_____other ______________________________.

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Behavioral Characteristics:

_____cooperative
_____attentive
_____willing to try new activities
_____plays alone
_____destructive/aggressive
_____easily frustrated/impulsive
_____stubborn
_____restless
_____poor eye contact
______easily distracted/short attention
______separation difficulties
_____inappropriate behavior
_____self-abusive behavior

If your child is in daycare/preschool/school, please answer the following:

- Name of school and grade in school:
  ____
  - Teacher's name:
    ____
  - Has your child repeated a grade? Yes_____ No_____
- What are your child's strengths and/or best subjects?
  ____
- Is your child having difficulty with any subjects?
  ____

Please tell me about your child (likes/dislikes/interests

____
____
____
____
____
____
____

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Insurance/Consent to Bill Insurance

Insurance Provider___________________________

Identification Number___________________________

GroupNumber______________________

Policy Holder's Name___________________________________

Policy Holder's Social Security Number_____________________________

Policy Holder's Date of Birth___________________________

I,______________________________,authorize Speech by the Beach, LLC, to electronically bill my insurance company for services provided to my child,____________________________________.

Signature____

Relationship___________________________________Date____________________________

Consent to Evaluate and/or Provide Therapy

Speech-language evaluations consist of observations, clinical judgment, and standardized testing. I acknowledge that standardized testing is not always possible, depending on a child's ability level. Results of the evaluation will determine if treatment is recommended.

I,_________________________________, authorize Speech by the Beach, LLC, to evaluate and/or provide treatment, including but not limited to video and audio recordings, to my child,______________________________,

Date of Birth_____________________.

Signature____

Relationship___________________________________Date____________________________

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HIPAA Consent

I give Speech by the Beach, LLC my consent to use or disclose my protected health information to carry out my child's treatment, to obtain payment from insurance companies, and for health care operations such as quality reviews. I have been informed that I may review the clinic's Notice of Privacy Practices for a more complete description of uses and disclosures before signing this consent. I understand that Speech by the Beach, LLC has the right to change its privacy practices and that I may obtain any revised notices at the clinic. I also understand that I may revoke this consent at any time (except for information already used or disclosed) by making a request in writing.

Printed Name_______________________________

Client's Name______________________

Signature____

Relationship__________________________________Date___________________________

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Cancellation/Office/No-Show Policy

We request you notify us **24 hours** prior to your appointment if you need to cancel or reschedule. If you do not call prior to your appointment time, you will be charged a **$25** no show fee that will need to be paid prior to any further services rendered. Please note that insurance providers do NOT reimburse for missed appointment charges. If your child misses 3 or more sessions within a 6 week period, Speech by the Beach, LLC reserves the right to discontinue services, until scheduling conflicts are resolved.

I acknowledge that if late for a session, I will be charged the full amount and the session will still finish at the scheduled time.

I acknowledge that the adult responsible for taking my child to therapy is expected to remain on premises for the duration of the session.

Payment/Insurance Authorization

I authorize for all insurance payments to be made directly to Speech by the Beach, LLC for therapy services rendered. I acknowledge that I am financially responsible for all charges not covered by my insurance. I acknowledge I am responsible for checking my financial responsibilities with my insurance carrier. I further acknowledge that my insurance company may deny and/or limit therapy benefits. I will be responsible for all charges accrued if my insurance denies services.

I understand it is my responsibility to track visits when authorizations expires. Speech by the Beach, LLC will do its best to send courtesy reminders. If therapy is conducted without current insurance authorization, insurance will not cover services, and I acknowledge I am responsible for payment of these sessions. I understand that I am responsible for any/all bank fees resulting from any bounced checks.

I understand that my co-pay is due at the time of my visit. I acknowledge I am responsible for any deductibles that apply. I acknowledge services will be terminated after 3 unpaid co-pays or unpaid therapy sessions, unless special arrangements have been made.

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Out-of-Network and Self Pay:

I acknowledge I am responsible to pay for services. Payment is due at time of visit. It is my responsibility to submit to my insurance for out-of-network reimbursement. If submitting for out of network reimbursement, Speech by the Beach, LLC will provide an invoice for each visit along with evaluation and progress notes when necessary.

I acknowledge services will be terminated after three unpaid sessions, unless special arrangements have been made with Speech by the Beach, LLC. I understand that I am responsible for any/all bank fees resulting from any bounced checks.

Fee Schedule Billed to Insurance:

Comprehensive Speech and Language Evaluation CPT code 92523 = $300.00
Speech Only Evaluation CPT code 92522 = $150.00
Speech therapy session CPT code 92507 = $100.00 30 minutes
Comprehensive Occupational Therapy Evaluation = $300.00
Occupational Therapy $200.00 per hour

Speech by the Beach, LLC only accepts cash or check.

- *I have read and fully understand the above consent for treatment, release of medical information, and payment/insurance authorization.*
- *I have fully read and agree to the cancellation/office/ no-show policy as described above.*
- *I acknowledge that I have received written explanation of the fee schedule, cancellation policy, and payment policy and I agree to all*

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Provider's Name: Speech by the Beach, LLC
Provider's Address: 199 New Road Unit #38 Linwood, NJ 08221

Printed Name________________________ Child's Name______________________

Signature____

Relationship__________________________________Date__________________________

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Authorization to Release Medical Records

Records to be Released From/To
Business Name: **Speech by the Beach, LLC**
Practicing Location: **1099 New Road Unit #38**
City, State, Zip: **Linwood, NJ 08221**

Records to be released To/From

Name	Email	Phone	Initial and Date

I, ____ give my permission to Speech by the Beach to speak with the above listed professionals regarding my son/daughter ______________________________,Date of Birth_________________________

Information exchanged may include but is not limited to speech/language screening summaries, evaluation reports, progress notes, treatment plans, session notes, previous medical history, as well as any necessary verbal communication pertaining to the child. Information may be exchanged via written reports, email, phone, fax, or in person. This information will be used for diagnostic and treatment purposed only. I acknowledge that this information will be kept confidential and will not be disclosed with another entity without my prior knowledge. I understand that I may withdraw this authorization at any time. I further acknowledge that the exchange of this information is in the best interest of my child in an effort to provide the highest quality of care possible. This consent is good for the duration of your child's treatment at Speech by the Beach, LLC.

Signature_____________________________________Relationship_____________________