A WAY WITH WORDS, LLC
867 Eastwind Drive
Westerville, OH 43081
(614) 600-2261
info@a-waywithwords@gmail.com

SPEECH/LANGUAGE THERAPY
CLIENT INTAKE PACKET

Client's Full Name: _____

Client's DOB: _____ **Age:** _____ **Gender:** ☐ **Female** ☐ **Male**

Address: _____

City: _____ **State:** _____ **Zip:** _____

Parent/Guardian Name: _____ **Relationship to Client:** _____

Parent/Guardian: **Home Phone:** _____ ☐ OK to leave message

Work Phone: _____ ☐ OK to leave message

Cell Phone: _____ ☐ OK to leave message

Parent/Guardian Email: _____

EMERGENGY CONTACT INFORMATION

1) _____ _____ _____
Name Phone Number Relationship to Client

2) _____ _____ _____
Name Phone Number Relationship to Client

Authorization is hereby given to A WAY WITH WORDS staff to release the above named client to the following persons, provided proper identification:

1) _____ **2)** _____
Name & Relationship to Client Name & Relationship to Client

Physician to be contacted in an Emergency:

Name: _____ **Phone:** _____

*I, the undersigned authorize the staff of A WAY WITH WORDS to take what emergency medical measures are deemed necessary for the care of my child.

X _____
Signature of Parent/Guardian Date

Case History

Client History & Concerns:

Child's Current Health Status (please circle one): Excellent Good Fair Poor

Date of most recent physical examination or doctor's visit: _____

Does your child have any medical conditions or diagnosis(s)?: ☐ Yes ☐ No

If yes, please list: _____

_____

Please list any medications your child is currently taking: _____

_____

Does your child have identified allergies?: ☐ Yes ☐ No
If yes, please list: _____

_____

Has your child had a history of any of the following: Chicken Pox, Measles, Scarlet Fever, Pneumonia, Influenza, Asthma, Hay Fever, Seizures, Asthma, Mumps, High Fevers, Whooping Cough, Ear Infections, Meningitis, Respiratory Illness.
☐ Yes ☐ No If yes, please list and elaborate: _____

_____

Surgeries/Infection (i.e. tonsils removed, adenoids removed)?: ☐ Yes ☐ No
If yes, please list surgery and when it occurred**:** _____

Hearing:

Does your child have a history of ear infections?: ☐ Yes ☐ No
If yes, how many?:_____ Age of first occurrence?:_____ When was last occurrence?:_____

Has your child ever had pressure equalizing (PE) tubes inserted?: ☐ Yes ☐ No
If yes, when were they inserted?:_____ In both ears?:_____ Currently still in place?:_____

Has your child's hearing ever been screened or tested? : ☐ Yes ☐ No
If yes, results:_____
*Any hearing concerns/issues at this time:_____

Prenatal/Birth/Delivery:

Were there any complications prior to, during, and/or related to your child's birth (including feeding)?
☐ Yes ☐ No

If yes, please elaborate: _____

Did your child attain Developmental Milestones at appropriate/indicated ages?: ☐ Yes ☐ No

School History (if appropriate):

School Name: _____ **Grade Level:** _____

Does your child have an IEP or 504 Plan?: Yes No

If yes, please list the services that your child receives: _____

Speech History:

Has your child ever had his/her speech and language skills evaluated in the past?: ☐ Yes ☐ No

If yes, please provide dates and agency:_____

Has your child ever received speech and language therapy in the past?: ☐ Yes ☐ No

If yes, please provide dates and agency:_____

Has your child ever received any special other therapies (i.e., OT, PT)?: ☐ Yes ☐ No

If yes, please provide type, dates and agency:_____

_____

Is there a family history of speech-language disorders?: Yes No

If yes, please elaborate (provide relationship to client, speech-language disorder, etc.): _____

_____

Please complete the following with a brief description of your concerns for your child's development and functioning in the following areas.

Language - uses words and sentences expected of his/her age, uses and understands age-appropriate grammar and vocabulary, uses language to get basic wants and needs met, understands what is said to him/her and follows directions	CONCERN AT THIS TIME? **YES** **NO** IF YES, PLEASE EXPLAIN:
Social Skills - participates in conversation, uses appropriate eye contact, uses and understands nonverbal language, seeks out interaction with others, understands the perspective of others	CONCERN AT THIS TIME? **YES** **NO** IF YES, PLEASE EXPLAIN:
Play Skills - plays with a wide variety of toys and plays with other children in an age appropriate manner	CONCERN AT THIS TIME? **YES** **NO** IF YES, PLEASE EXPLAIN:
Articulation - produces sounds when speaking in an age appropriate manner and is easily understood by others	CONCERN AT THIS TIME? **YES** **NO** IF YES, PLEASE EXPLAIN:
Feeding - eats a wide range of foods from all food groups and tries new foods	CONCERN AT THIS TIME? **YES** **NO** IF YES, PLEASE EXPLAIN:

with little difficulty, eats with age appropriate utensils, has no difficulty chewing and swallowing	
Behavior - transitions between activities, follows rules and social expectations, handles disagreements and problems in age-appropriate ways	CONCERN AT THIS TIME? **YES** **NO** IF YES, PLEASE EXPLAIN:
Sensory - tolerates sensory input from the environment, including, but not limited to a variety of sounds, light, smells, touch, and movements. Does not have issues with clumsiness, or the ability to sit still	CONCERN AT THIS TIME? **YES** **NO** IF YES, PLEASE EXPLAIN:

What are your child's strengths? _____

_____

What are your child's interests/motivators/favorite toys? _____

_____

In what areas do you need assistance to best support your child in his/her home, school, and community? _____

_____

Additional Pertinent Information: _____

_____

Attendance/Cancellation Policy

At A WAY WITH WORDS, LLC, it is understood that at times, therapy sessions need to be cancelled due to illness, family emergencies, vacations, weather, etc. If you must cancel an appointment that you have scheduled, please directly contact A WAY WITH WORDS, LLC immediately (via phone or email). Except under emergency circumstances, all appointments cancelled with less than *24 hours notice* will be subject to a $50 service fee. In the event that you arrive late for an appointment, A WAY WITH WORDS, LLC will do its best to see your child, however the appointment may be shortened due to time constraints; the full session fee still applies. Please note that most funding agencies will not reimburse for missed appointments and you will remain responsible for these charges.

In the event that a therapist must cancel a session, every effort will be made to schedule a make-up session for your child. When you must cancel a session in advance, the therapist will attempt, with no guarantee, to schedule a make-up session for your child.

If a client is unable to maintain 75% attendance for scheduled sessions, he/she may be discharged from therapy services; 2 "no call-no shows"/failure to contact A WAY WITH WORDS, LLC regarding a session cancellation also results in discharge from therapy services.

I, _____ parent/caregiver of _____ state that I have received a copy of A WAY WITH WORDS, LLC's Attendance and Cancellation policy, have read, and understand all contents and expectations outlined within.

X _____

Parent/caregiver Signature **Date**

Payment Policy

I, _____, parent/caregiver of _____, select to use the following funding source(s) to cover fees incurred at A WAY WITH WORDS, LLC.

SPEECH LANGUAGE THERAPY SERVICES:

- ☐ Self/Private Pay
- ☐ Delaware County Board of Developmental Disabilities (DCBDD)
- ☐ Autism Scholarship/Jon Peterson Scholarship
- ☐ Other – Please indicate:

Party Responsible for Payment:

I, _____ , authorize the release of any payment and medical information necessary to process my or my family member's claim and related claims. I hereby authorize payment directly to A WAY WITH WORDS, LLC of the benefits otherwise payable to me for all professional services.
Signature of Parent/Guardian Date
*Required only if using third party funding sources for therapy services

A WAY WITH WORDS, LLC will always inform you of the charges prior to providing any type of clinical service. A schedule of fees can be obtained from A WAY WITH WORDS, LLC at any time. Fees apply to various types of services including direct client contact (clinic based or offsite), phone consultations, travel, and consultation with other professionals.

The person who completes the Party Responsible for Payment section is responsible for payment of all services rendered. In most cases, payment is due at the time services are rendered unless you have made other arrangements in advance (which will be documented in writing). For children scheduled for individual therapy without a parent present, payment should be made in advance or be sent with the child (services will not be provided otherwise). Accounts more than 30 days overdue will be subject to a $20 late fee and 5% interest charge. Accounts more than 60 days overdue will be sent to collection. For clients seeking third-party reimbursement, please be aware that you are ultimately responsible for the payment of services rendered. In the event that your third party funding source denies payment (including recoupment) or does not remit payment within 45 days, the client will be responsible for payment of all services rendered. A WAY WITH WORDS, LLC may at times provide discounts or fee waivers for families with extenuating circumstances; however, it is the client's responsibility to ensure that acceptance of such fee reductions will not adversely affect third-party payment obligation.

I, _____ parent/caregiver of _____ state that I have received a copy of A WAY WITH WORDS, LLC's Payment policy, have read, and understand all contents and expectations outlined within.

X _____

Parent/Caregiver Signature **Date**

Authorization for Release of Information Form

Completion of this form will serve as written permission for A WAY WITH WORDS, LLC to communicate with the individuals and/or agencies you have listed below. Communication with those you identify allows for the release and reception of information which includes but is not limited to evaluations, progress reports, session notes, etc. This type of communication allows for the coordination [among other professionals] of services, techniques, and treatment strategies; updates about progress toward goals and; the ability to provide continuity of services.

Client Name: _____ **Date:** _____

I hereby give authorization to A WAY WITH WORDS, LLC to release or receive information to/from the following: (list names and contact information of individuals and/or agencies – i.e. schools, hospitals, primary care physicians, etc.):

_____

_____

_____

Communication to/from these individuals may occur in a variety of ways (in person, phone conversations, email, fax transmittals, etc.) and may include information from the patient's medical record, for example, speech-language evaluation results or effective speech-language therapy strategies and techniques. Please know you have the right to restrict *how* information about you or your child is shared. Kindly indicate any restrictions you wish to request regarding how information about you or your child is shared with the above named individuals and/or agencies.

_____I do not have any restrictions with how information is shared.
_____I wish to apply the following restrictions (i.e. phone calls only, no emails, etc): _____

_____

This authorization will be considered valid throughout the course of treatment unless otherwise requested by the patient and/or guardian(s).

X_____
Parent/Caregiver Signature **Date**

Printed Name: _____ **Relationship to client:** _____

Photo/Video/Multimedia Release Form

I, the undersigned, hereby grant A WAY WITH WORDS, LLC permission to make videotapes, multimedia, still pictures, and sound recordings, separately or in combination of my child, _____.

I also give A WAY WITH WORDS, LLC permission to use the finished videotapes, multimedia, still pictures, and/or sound recordings for presentation and teaching purposes. Further, I relinquish and give to A WAY WITH WORDS, LLC all rights, title, and interest I may have in the finished videotapes, multimedia, still pictures, and/or sound recordings, negatives, prints, reproductions, and copies of the originals, negatives, recording duplicates, and prints for educational or instructional purposes only.

Additional confirmation will be made if photographs, videotapes, multimedia, or recordings are to be used for promotional purposes.

_____

Child's printed name

X_____

Parent/Caregiver Signature **Date**

Policies and Procedures

Attendance/Cancellation:

At A WAY WITH WORDS, LLC, it is understood that at times, therapy sessions need to be cancelled due to illness, family emergencies, vacations, weather, etc. If you must cancel an appointment that you have scheduled, please directly contact A WAY WITH WORDS, LLC immediately (via phone or email). Except under emergency circumstances, all appointments cancelled with less than *24 hours notice* will be subject to a $50 service fee. In the event that you arrive late for an appointment, A WAY WITH WORDS, LLC will do its best to see your child, however the appointment may be shortened due to time constraints; the full session fee still applies. Please note that most funding agencies will not reimburse for missed appointments and you will remain responsible for these charges.

In the event that a therapist must cancel a session, every effort will be made to schedule a make-up session for your child. When you must cancel a session in advance, the therapist will attempt, with no guarantee, to schedule a make-up session for your child.

If a client is unable to maintain 75% attendance for scheduled sessions, he/she may be discharged from therapy services; 2 "no call-no shows"/failure to contact A WAY WITH WORDS, LLC regarding a session cancellation also results in discharge from therapy services.

Confidentiality:

Your privacy is very important to A WAY WITH WORDS, LLC. I strongly recommend that you review the Notice of Privacy Policy for important details regarding policies for maintaining confidentiality. In particular, you should be aware that A WAY WITH WORDS, LLC will only contact you via means that you have specifically authorized in your new client paperwork. If you would like me to exchange information with persons other than yourself, an Authorization for Release of Information form must be completed (included in the client intake packet).

Fees:

A WAY WITH WORDS, LLC will always inform you of the charges prior to providing any type of clinical service. A schedule of fees can be obtained from A WAY WITH WORDS, LLC at any time. Fees apply to various types of services including direct client contact (clinic based or offsite), phone consultations, travel, and consultation with other professionals.

Payment:

The person who completes the Party Responsible for Payment section is responsible for payment of all services rendered. In most cases, payment is due at the time services are rendered unless you have made other arrangements in advance (which will be documented in writing). For children scheduled for individual therapy without a parent present, payment should be made in advance or be sent with the child (services will not be provided otherwise). Accounts more than 30 days overdue will be subject to a $20 late fee and 5% interest charge. Accounts more than 60 days overdue will be sent to collection. For clients seeking third-party reimbursement, please be aware that you are ultimately responsible for the payment of services rendered. In the event that your third party funding source denies payment (including recoupment) or does not remit payment within 45 days, the client will be responsible for payment of all services rendered. A WAY WITH WORDS, LLC may at times provide discounts or fee waivers for families with extenuating circumstances; however, it is the client's responsibility to ensure that acceptance of such fee reductions will not adversely affect third-party payment obligation.

Health Insurance:

A WAY WITH WORDS, LLC does not currently participate with insurance companies. As a result, A WAY WITH WORDS, LLC does not accept payment through insurance or managed care companies; further, we do not bill them. We are able to provide receipts, though, which you can personally submit to your insurance company for possible reimbursement for out-of-network outpatient speech therapy. Please be advised that many health insurance plans have limited coverage for speech-language pathology services. A WAY WITH WORDS, LLC recommends that you contact your insurance company to discuss the limits of your coverage.

Termination of Services:

In the event that you do not keep your financial obligations to A WAY WITH WORDS, LLC and remain delinquent on your account for more than 60 days, services will be suspended until payment is received. Services may also be terminated if it is determined that continued participation will be a detriment to the child or their family.

Health:

Help and cooperation is required in order to maintain a healthy environment. A child must be temperature-free for 24 hours before returning to therapy. If your child has vomiting and/or diarrhea, he/she should not return to therapy until 24 hours have passed since the last episode of the same. Children will not be seen if any of the following is present:

- Too ill or uncomfortable to function in the therapy setting;
- Continual runny nose;
- Thick or discolored nasal discharge;
- Excessive sneezing or coughing and mucus-producing cough;
- An elevated temperature.

I, _____parent/caregiver of _____ state that I have received a copy of A WAY WITH WORDS, LLC's Policies and Procedures, have read, and understand all contents and expectations outlined within.

X _____

Parent/Caregiver Signature **Date**

Privacy Rights

HIPAA Notice of Privacy Practices
A WAY WITH WORDS, LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We may change the terms of this Notice in the future. We reserve the right to make changes and to make the new Notice effective for all protected health information that we maintain. If we make changes to the Notice, we will have copies of the new Notice available upon request (you may also contact our Privacy Officer at 330-507-4440 to obtain a copy of the current Notice).

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by A WAY WITH WORDS, LLC and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of A WAY WITH WORDS' practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your healthcare with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for the treatment.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of speech pathology students, licensing, marketing and fund raising activities, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your therapist. We may also call you by name in the waiting room when your therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization at any time in writing, except to the extent that your physician or the physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information.

This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. In the case of a child custody issue, we will need a legal documentation stating that no information is to be released to the person to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes.

You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before July 1, 2019.

A WAY WITH WORDS, LLC Contact:
Lorin Pankewicz, M.A., CCC-SLP
(614) 600-2261
lorinpankewicz@a-waywithwords.com
OR
info@a-waywithwords.com

I, _____parent/caregiver of _____
acknowledge that I have been notified of the privacy practices set forth in the Notice of Privacy Practices.

X _____

Parent/Caregiver Signature **Date**