The Kids' Communication Center
4906 Wisconsin Ave., NW
Washington, DC 20016
202-237-7079
fax: 202-237-8480
dlglaser@msn.com

CLIENT INFORMATION

Child's Name: _____
(Last) (First) (Middle)

Date of Birth: _____ Sex: _____ Responsible Party: _____

Today's Date: _____ Relationship to Child: _____

Telephone Numbers: _____
(Home) (Work) (Cell)

Address: _____ E-mail: _____

Name, Phone, E-mail of Nanny/Caregiver:_____

Does your child have any siblings? _____ If yes, what are their ages? _____

Pediatrician: _____ Pediatrician's Address: _____

Has your child ever been given a medical diagnosis? _____ If yes, what diagnosis? _____

What was the treatment? _____

Were there any complications (e.g., maternal health problems, bed-rest, medications) with the pregnancy? _____ Explain. _____

_____

How long was the mother on bed-rest? _____

Was your child born premature? _____ Please provide details as to difficulties and treatment. _____

_____

_____

Were there any complications during labor and/or delivery (e.g., forceps, vacuum extraction)? Explain.
_____

Apgar scores: _____

Child's birth weight: _____

Was your child admitted to the NICU? _____ If so, explain (include length of stay). _____

_____

Was your child nursed? _____ If so, until what age? _____

Was there anything remarkable about your child's early feeding history? _____

Has your child ever suffered from ear infections? _____ If yes, how many? ____ Which ears? _____

At what age(s)? _____ Were PE tubes inserted? _____ If yes, at what age? _____

Does your child have fluid in his/her ears? _____ If yes, for how long? _____

Has your child's hearing been tested? _____ When? _____

Where? _____ What were the results? _____

Is your child sensitive to certain sounds/pitches (e.g., vacuum cleaners, blenders)? _____

Does your child cover his/her ears when he/she hears certain sounds? (specify) _____

Does your child seem under-reactive to loud sounds (e.g., ambulance)? _____

Is your child on any medications? (specify) _____

Does your child have any allergies? (specify) _____

Did your child ever suffer from reflux? _____

Were any medications prescribed? _____

Explain your child's typical eating habits: _____

_____

Does your child crave food? _____ If yes, please list: _____

Does your child have any food allergies? _____yes _____no _____never tested

If yes, describe. _____

When eating, does your child prefer specific textures (e.g., mushy, crunch), tastes (e.g., sour, sweet, bland) or temperatures (e.g., hot, cold)? _____

What is the texture of the child's stools (liquid/formed/paste) _____

Please provide examples of regularly consumed foods that are:

Mushy _____ Crunchy _____

Chewy _____ Sour _____

Sweet _____ Bland _____

Cold _____ Hot _____

Please describe a typical breakfast. _____

Please describe a typical lunch. _____

Please describe a typical dinner. _____

Please describe typical snacks. _____

Does your child drink from an open cup? _____ Use a straw? _____

Does your child use a pacifier? _____ At what age did he/she stop? _____

Does your child suck his/her thumb? _____ At what age did he/she stop? _____

Does your child eat from a fork? _____ Spoon? _____

Does your child feed him/herself with a fork? _____

Does your child put toys and fingers in his mouth? _____

Does your child drool? _____

Can your child blow bubbles? _____

Can your child blow whistles? _____

What languages are spoken in the home or in any of your child's other settings? _____

Does your child communicate with gestures? _____ Sounds (e.g., grunts)? _____

At what age did your child begin using one-word utterances? _____

Two-word utterances? _____

Give examples of several phrases your child often uses (e.g., "want milk") _____

_____

Do others understand your child when he/she communicates? _____

Do you understand your child when he/she communicates? _____

Is your child showing signs of frustration arising from his/her communication? _____

At what age did your child begin to crawl? _____ To walk? _____

Describe your child's crawl. _____

Does your child interact well with peers? _____ With adults? _____

Does your child make eye contact with others? _____

List other professionals working with (or who have worked with) your child:

Names/Professions: Phone Numbers:

_____ _____

Has your child been treated by another speech-language pathologist? (Please provide name, telephone number, and reason). _____

_____

Does your child attend school, day-care, or other program? (specify name, days attended, and length of day) _____

_____

Describe the child's current activity level (low, typical, high). _____

What is the child's current sleep pattern?
Sleeps from _____ to _____ Naps from _____ to _____

What activities does your child enjoy the most? _____

What activities does your child refuse to do? _____

How does your child spend most of his/her time? _____

How much time does your child spend watching television per day? _____

Does your child have difficulty calming him/herself? _____

Does your child respond to his/her caregiver with a facial expression, gesture, or vocalization? Y / N

Does your child show back-and-forth communication (e.g., gesture, facial expression, or verbalization) with his/her caregiver? For example, mom smiles at child, child coos, then mom coos and child reaches to be picked up, then mom smiles and then baby laughs). Y / N

Which of the following concern you? (check all that apply)

_____ 1) number of words your child uses in a sentence
_____ 2) your child's pronunciation of words
_____ 3) your child's ability to understand language
_____ 4) your child's play/social skills
_____ 5) your child's eating habits
_____ 6) your child's ability to maintain attention
_____ 7) your child's ability to read
_____ 8) your child's ability to use language to converse (back-and-forth dialogue)

Please explain. _____

_____

Does your child repeat a word or sound within an utterance (e.g., "like like like this one mom")? _____

How many times does your child repeat the repeated sound or word? Two or less _____

Three or more? _____

How many times a day does your child repeat a word or sound within an utterance? _____

Is your child repeating sounds, syllables, or words? (Provide examples) _____
_____

How long has your child been repeating sounds, syllables, or words? (Provide approximate dates) _____

_____

Is your child left-handed or right-handed? _____

What do you hope therapy will accomplish? _____

_____

Who will implement a speech and language home program? _____

Who recommended that you see a speech-language pathologist? _____

How did you hear about The Kids' Communication Center? _____

Have other family members been treated by a speech-language pathologist? _____

If so, why? _____

Have any immediate family members been diagnosed with autism? _____

Have any extended family members been diagnosed with autism? _____

Do you plan on filing for insurance reimbursement? _____ Name of insurance: _____

Name of insured: _____ Policy No.: _____

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FEE SCHEDULE

Speech-language evaluation……..$260.00
*Fee includes written report and one hour of testing.
*If the testing is not completed within a one-hour session, $130 will be added for each additional hour of testing.

Speech-language therapy (individual at office)……....$130.00 per hour*

Speech-language therapy (individual at school)…….$135.00 per hour

Consultative services (at office)……...…..$130.00 per hour

Consultative services (at home or school)……..$135.00 per hour

Group therapy sessions (at office)……...……..$90.00 per hour**

Group therapy sessions (at school)……...……$95.00 per hour

*Please note that the last 5-10 minutes of each one-hour session will be reserved for communication with the parent/caregiver regarding treatment, progress, and suggestions for at-home practice.

**If a dyad/group session becomes an individual session due to another child's cancellation, you will be billed for an individual session.

CANCELLATION POLICY

Cancellations made less than 24 hours in advance are billed at the full rate of service except in an emergency. Please try to give as much notice as possible if there is to be a cancellation.

PAYMENT SCHEDULE

Payment is due at time of service or upon receipt of invoice.

_____ _____
Responsible Party/Parent Date

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CONSENT FOR SERVICES

I _____ (parent/guardian), give my permission to The Kids' Communication Center, LLC to exchange information with the following physicians, programs, or other persons:

_____ _____

_____ _____

_____ _____

about _____, whose date of birth is _____.
(name)

I also give permission for The Kids' Communication Center, LLC to provide information, treatment, and consultative services to the above-mentioned client.

I understand that the fees for services provided are due upon receipt of the invoice.

_____
(legal guardian signature) (date)

_____
(witness) (date)

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

• Conduct, plan, and direct my 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.
• Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

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TERMS OF PAYMENT AGREEMENT

I, _____ acknowledge and accept full and complete responsibility for prompt payment of all services rendered to _____ by The Kids' Communication Center, LLC. I acknowledge that prompt payment is upon receipt of invoice. I acknowledge that I have received written explanation of the fee schedule and the cancellation policy and that I agree to both.

I understand that health insurance policies and reimbursement are between myself and the health insurance company, that all services rendered to my child are charged directly to me, and that I am personally responsible for payment to The Kids' Communication Center, LLC. I understand that agreements regarding fee schedules and charges for canceled appointments are between myself and The Kids' Communication Center, LLC, and are not related to potential health insurance coverage.

_____

(signature of parent/guardian) (date)

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CREDIT CARD FORM

I, _____, acknowledge and accept full and complete responsibility for prompt payment of all services rendered to my son/daughter, _____, by The Kids' Communication Center, Inc.

I understand that I will receive an invoice via e-mail from "The Kids' Communication Center, Inc." following my child's services and that my credit card will be charged in full for the services. If the credit card is declined, I agree to pay a 5% processing fee and understand that my child's services will be suspended until the payment is received.

I understand that health insurance policies and reimbursement are between myself and the health insurance company and that The Kids' Communication Center does not accept third party payments from insurance companies. Any payments received by the third party will be immediately returned to the insurance company.

I understand that cancellations must be made 24 hours in advance or I will be billed at the full rate. It is important for The Kids' Communication Center to have sufficient notice in order to schedule make-up sessions with other clients.

I understand that The Kids' Communication Center does not close for holidays or inclement weather unless contacted by my child's therapist. If I need to cancel in these situations, I understand that I must contact my child's therapist by 7 a.m. that day or I will be billed at the full rate.

e-mail_____

Name on credit card_____

Credit Card number_____

Credit Card type Visa Mastercard
(WE CAN'T ACCEPT AMEX)

Address _____

_____

Expiration Date_____

Three digit code on back of card_____

By signing this form, I am stating that I received a written explanation of the fee schedule and I agree to all terms of the policy.

_____ _____
Signature of guardian Date