CROSSROADS SPEECH THERAPY

Katie Dimond MA CCC-SLP
2922 N Seeley Ave Chicago,
60618
(847)924-2390
Katie@crossroadsspeechtherapy.com

Patient Intake Form

Child's Name:
Address:
Phone:
Email:
Child's Date of Birth:
Child's Age:
School/Preschool/Daycare
Grade:
Person filling out this form:
Spouse's name:
Referral Source:

Name on Credit Card:	
Credit Card Number:	
Expiration Date:	
CVC (3-digit code on back)	
Billing Zip Code	

Reason for referral:

Physician:

Birth history:

Full term Premature (wks)

Past Medical History:

Is your child currently taking any medications?

Does your child have a medical diagnosis?

Is your child allergic to anything?

Date and location of last hearing evaluation:
What were the results of the last hearing evaluation?

Concern:

1. When did you first have concerns about your child?

2. What made you concerned?

3. What strategies or techniques have you been trying independently?

4. What are your child's interests and how can I make speech therapy engaging and fun for your child while still meeting our goals?

5. What languages do you and your family speak? How often are those languages spoken?

6. What days and times is your child free for speech therapy? Please suggest a few times and days of the week.

My child	Yes	No
1. Can say at least 5- words.		
2. Imitates words.		
3. Speaks in syllable strings with inflection similar to adult speech.		
4. Names objects in photographs or books.		
5. Uses gestures and vocalizations to request objects.		
6. Uses words more often than gestures to communicate.		
8. Uses representational gestures and baby sign language (please, thank you, more, help, waving hi and bye, clapping, moves his body.)		
9. Follows commands with gestural cues.		
10. Identifies basic body parts.		
11. Identifies things you wear.		
12. Engages in symbolic play. pretend play.		
13. Engages in pretend play.		

Feeding Milestones
Approximate age your child began to do the following:

Breast:	Bottle:	Purees:	Table Foods:	Sip Cup:	Straw:	Open Cup:

Early Feeding History:
Was your child breast fed? Yes No
For how long?
Please describe any difficulties:_____
_____
Was your child bottle fed?Yes No
For how long?
Please describe any difficulties:_____
_____
Did your child use a pacifier?Yes No
When did they stop?
Did your child suck their thumb?Yes No
When did they stop?
How did your child tolerate formula?
What formula?
How did you child tolerate pureed food?

How did your child do with the transition to solid foods?

If your child is in school, please answer the following:
Name of School:
Grade/Classroom:
Teachers Name:
Teachers Phone:
Has your child repeated a grade?Yes No
What are your child's strength/best subjects in school?
_____
_____
____
Is your child having difficulty or receiving help with any subjects?
_____
_____
____
Any other pertinent information you would like to share?
_____
_____

Payment and Financial Policy:
I acknowledge Crossroads Speech Therapy will bill BCBS, United Health Care, or Aetna insurance. Your insurance provider will send payment directly to Crossroads Speech Therapy. The client will be responsible for the cost of sessions until the deductible has been met. Once the deductible has been met the client will be responsible for the co-pay.

Private Pay Clients will be charged for services at time of services at the private pay rate.

Crossroads Speech Therapy is committed to recommending the best treatment for our patients regardless of coverage. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates, determination of medical necessity, and treatment records received that may determine ineligible expenses under the patient's health benefit plan. Your insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. As a reminder, all fees are due at the time of service.
I hereby authorize Crossroads Speech Therapy to bill the credit card I have provided above to keep on file for services rendered, and agree to take all further actions required to pay the charges in full and to perform the obligations set forth in my agreement with my credit card issuer.

I have read, understand and agree to this policy.

Sign Name: _____
Date: _____

Here is how it works: Your services are submitted to insurance. At the beginning of each month you will be responsible for the amount that insurance didn't cover and it will be charged to your credit card account. It's as simple as that!

Cancellation Policy:
Please cancel at least 12-hours in advance of the session taking place. If sessions are cancelled within a 12-hour window of the session taking place there will be a $100.00 cancellation fee charged to the card on file.

Sign Name:_____
Date: _____

COVID-19 and Other Infectious Disease Policy:
I understand that Crossroads Speech Therapy will take all reasonably practicable measures to protect its clients and clinicians from exposure to the Novel Coronavirus or COVID-19, any mutation thereof, or any other virus or infectious disease (each an "Infectious Disease and collectively "Infectious Diseases") at in-person speech therapy appointments, including wiping surfaces with disinfectant and hand washing prior to each appointment.

Notwithstanding such measures, I understand and hereby acknowledge that due to the close contact required by the nature of the practice of speech language pathology, completely eliminating risk of exposure to Infectious Diseases is impossible.

I agree to follow Centers for Disease Control and prevention (CDC), local health guidelines, and Crossroads Speech Therapy policies and procedures for social distancing to reduce the spread of Infectious Diseases. When such policies are in place, I agree that my child, and any person accompanying my child to speech therapy appointments (including myself) will maintain the recommended level of social distancing from other persons to the extent possible, wear a protective face covering at all times (with certain exceptions made for the patient during an active speech language pathology session), and exercise frequent use of hand washing and hand sanitizer. I understand that this policy is in place for the protection of myself, my child, the speech language pathologist, as well as any other persons on the premises.

I agree that if my child, or any person accompanying my child to their appointment (including myself) has been sick or has experienced symptoms of an Infectious Disease at any time within the prior 14-days or has come in contact with someone who was sick or has experienced symptoms of an Infectious Disease over the prior 14-days, I will disclose the foregoing to Crossroads Speech Therapy prior to any appointment and cancel such appointment.

I understand that there is no medical health coverage afforded to me or my child through my relationship with Crossroads Speech Therapy. I hereby agree and acknowledge that Crossroads Speech Therapy is not responsible for any potential or actual exposure to any Infectious Disease, of myself, my child, or any person accompanying my child to any appointment.

Sign Name:_____
Date: _____

Waiver of Liability and Indemnification:

I hereby agree that Crossroads Speech Therapy is not liable for any injury or illness (including any physical injury, mental illness, virus or Infectious Disease) of my child, myself, or anyone accompanying my child to speech therapy appointments, except as as a direct result of gross negligence or willful misconduct of Crossroads Speech Therapy. I further agree to hold Crossroads Speech Therapy harmless against any such injury or illness, and to indemnify Crossroads Speech Therapy against any claims, actions, losses, or damages by myself, my child, or any third party relating to such injury or illness.

Sign Name:_____
Date: _____

HIPAA - SUMMARY OF PRIVACY NOTICE

1. OUR LEGAL DUTY

Our practice is dedicated to maintaining the privacy of current and former patients' health and financial information as required by our internal policies and applicable law. We are also required by federal law to give you this notice explaining your rights, our legal duties and privacy practices. We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all PHI(Personal Health Information) that we maintain, including PHI we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information contained in this Notice.

2. USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose PHI about you for treatment, payment, and healthcare operations. For example: Treatment: We may use or disclose your PHI to a physician or other healthcare provider providing treatment to you. Payment: We may use and disclose your PHI to obtain payment for services we provide to you. Healthcare Operations: We may use and disclose your PHI in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. Your Authorization: In addition to our use of your PHI for treatment, payment or healthcare operations, you may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your PHI for any reason except those described in this Notice. To Your Family and Friends: We must disclose your PHI to you, as described in the Patient Rights section (Block 3) of this Notice. We may disclose your PHI to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so. Persons Involved In Care: We may use or disclose PHI to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your PHI, we will provide you with an opportunity to object to such uses or disclosures.

In the event of your incapacity or emergency circumstances, we will disclose PHI based on a determination using our professional judgment disclosing only PHI that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of

your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of PHI. Marketing Health-Related Services: We will not use your PHI for marketing communications without your written authorization. Required by Law: We may use or disclose your PHI when we are required to do so by law. Abuse or Neglect: We may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. National Security: We may disclose to the military authorities the PHI of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials PHI required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected PHI of inmate or patient under certain circumstances. Appointment reminders: We may use or disclose your PHI to provide you with appointment reminders (such as voice-mails, e-mails, postcards, or letters).

3. PATIENT RIGHTS

Access: You have the right to inspect and obtain a copy of your protected PHI, with limited exceptions. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing, or other costs incurred by us as a result of complying with your request. Requests for access to your protected PHI must be made in writing. Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your PHI for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years. You must submit your request in writing to the contact information provided at the top of this notice. Your first request within a 12-month period is free of charge, but our practice may charge you for additional request made within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs. Requesting Restrictions: You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the contact information provided at the top of this notice. Your request, in a clear and concise manner should describe; the information you wish restricted, whether you are requesting to limit our practice's use, disclosure or both or to whom you want the limits to apply.

Alternative Communication: You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. Your request must be in writing and specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request. Amendment: You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your

request under certain circumstances. Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are still entitled to receive this Notice in written form.

4. QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the top of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Signature:_____
Date:_____