CONSENT FOR TELE-HEALTH SERVICES

I understand that APPLE FLATS SPEECH PATHOLOGY CLINIC LLC is providing tele-health services including but not limited to consultation, direct treatment, and virtual meetings. Tele-health allows meetings through audio and visual modalities using an internet provider and a HIPPAA compliant platform

DOXI.ME is the technology service we will use to conduct tele-health videoconferencing appointments.

I understand that tele-health has potential benefits including easier access to care and the convenience of meeting from a location of my home. In addition, tele-health reduces the risk of contracting or spreading colds, infections and/or viruses while still allowing you/your child to benefit from our services.

I understand there are potential limitations to engaging in tele-health, including interruptions in treatment due to technical difficulties. New evaluations as well as re-evaluations will continue to be conducted at the clinic.

I understand that my health care provider or I can discontinue the use of tele-health if it is deemed that the videoconferencing connections and available features are not adequate for the situation. I have the right to decline tele-health services at any time.

I understand that I am responsible to protect my or my child's HIPAA information by only engaging in tele-health sessions in a private location. This location should be free from distractions that may limit my or my child's progress.

Some insurances do not cover speech language pathology services that are delivered using tele-health. I understand that it is my responsibility to know my insurance coverage for services delivered through the use of tele-health.

Pricing, attendance policies and practice policies are the same for tele-health as they are for in person services.

I understand that the tele-health technology is able to be accessed from a computer, iPad or other mobile device. The technology works best on a computer and the use of a computer is recommended if possible.

To maintain confidentiality, I will not share my tele-health appointment link or account information with anyone unauthorized to attend the appointment.

I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND CONSENT TO THE ITEMS CONTAINED IN THIS DOCUMENT

Sign or type name Date

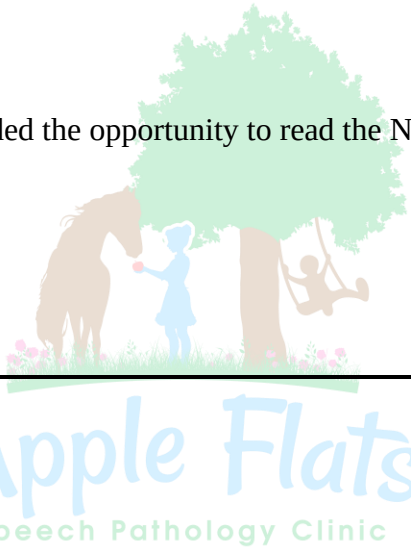
ACKNOWLEDGEMENT of PRIVACY PRACTICES

Patient Name: _____ Date of birth: _____

Social Security number: _____

I acknowledge that Apple Flats Speech Pathology Clinic LLC provided me with a written copy of its Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.



Patient Signature Date

_____

Personal Representative Signature (if applicable) Relationship to Patient Date

Apple Flats Speech Pathology Clinic LLC

Intake Date: _____ Contact email: _____

Full name of child: _____DOB:_____Age:_____Sex: Female _____

With whom does the child live:_____ Language(s) spoken in the home_____

Person providing intake:_____ Who referred child:_____

Primary care provider: _____ Phone: _____

Present medical diagnoses _____Speech Language Diagnosis _____

Mother's Name _____ Father's Name _____

Mother's phone: _____ Father's phone _____

Address: _____

Occupations: Mother _____ Father _____

ADOPTION HISTORY (***skip if it does not apply***)
Was your child adopted? No_⊙_ Yes_◯_ Other_◯_ (foster care, kinship care)
If yes, was it a domestic or international adoption? Domestic_⊙_____ International_◯_____
If domestically adopted, from what state was your child adopted? ____
If internationally adopted, from what country was your child adopted? ____
At what age was your child adopted? _____Was your child adopted with another biological sibling? N⊙Y◯__
If yes, how does their development differ from your child? _____
Do you have any other adopted/biological children? No _⊙_Yes_◯_
If yes, what age(s) are they and how does/did their development differ from this child? _____
Do you possess any verbal knowledge or written documentation regarding your adopted child's birth, medical, and developmental history?_____
If written documentation is available, please attach all copies of documentation to this form

PREGNANCY AND BIRTH HISTORY:
Maternal age_____ Paternal age_____ at the time of pregnancy
When you were pregnant with this child, were you under the care of a physician? Yes_◯_ No _◯_
Did you experience any difficulties or notable events (illness, accidents, trauma) during pregnancy?Yes⊙No◯
Was there any maternal yes _⊙_ no_◯_ paternal yes _⊙_ no _◯__ alcohol use during pregnancy?
Was there any maternal yes _⊙_ no _◯__paternal yes _⊙_no _◯__ drug use during pregnancy?
Length of pregnancy: weeks_____ Child's birth weight _____ lb oz
Were there any birth or medical complications? _____
Known family history of speech or language problems? N⊙Y◯
Known family history of special education placements or learning disabilities? N⊙Y◯
Known family history of mental health difficulties/psychiatric diagnoses? N⊙Y◯
Known family history of substance abuse (e.g., illicit drugs, alcohol, prescription medication)? N⊙Y◯
Known family history of abuse or neglect (e.g., physical, sexual, emotional, etc)? N⊙Y◯

If you answered YES to any of the above questions please explain or describe here and on the back:

_____

_____ .

MEDICAL HISTORY:

Has any medical professional ever given your child a specific diagnosis? (mark all that apply)
Psychiatric Disorder☐ Autism Spectrum Disorder☐ Hearing Problems☐
Cerebral Palsy☐ Tic Disorder☐ Speech-Language Delay☐ Developmental Delay☐ Failure to Thrive☐ Seizure Disorder ☐ Intellectual Disability ☐ Alcohol Related Disabilit☐Head Injury ☐ Sleep Disorder ☐ Enuresis/Encopresis ☐ Cardiac Problems ☐ Metabolic Problems ☐ Immune Disorder ☐
Vision Problems ☐ Genetic Disorder ☐ Asthma ☐ Allergies ☐ Difficulty feeding/eating Other :☐

_____

RELATED SERVICES:

Has your child ever been previously seen by a/an
__☐__Speech-Language Pathologist __☐__Audiologist _☐_Physical Therapist _☐_Occupational Therapist
_☐_Educational Tutor _☐_ENT_☐_Psychologist __☐__Geneticist _☐__Developmental Specialist (EI)
_☐_Neurologist _☐_Psychiatrist __☐__Neurodevelopmental Pediatrician
If yes, please specify (dates, diagnoses, type of services provided such as evaluation, therapy):
_____

HEARING:

Does your child:

- Talk in a loud voice Yes ◯ No ◯
- Turn up the volume on the radio and TV? Yes ◯ No ◯
- Hear you if his or her back is turned? Yes ◯ No ◯
- Hear you talk to him or her from the other room? Yes ◯ No ◯
- Have a history of ear infections? Yes ◯ No ◯
- Had a hearing screening or evaluation? Yes ◯ No ◯
- Have excessive wax or buildup that is visible? Yes ◯ No ◯
- Seen and Ear Nose and Throat specialist? Yes ◯ No ◯

If no, do you have any concerns regarding your child's processing of language? (listening comprehension)
understanding verbal directions and instructions No ◯ Yes ◯
Does your child ask you to frequently repeat information/questions? No ◯ Yes ◯
Does your child require extended processing time to answer questions? No ◯ Yes ◯

DEVELOPMENT:

Motor Milestones (age achieved in months)
Sat alone: Crawl: ___Sit_____ Pulled up _____Say first word ___ Walked: ___Learn simple games (peek-a-boo)
Potty trained: _____

Sleep

Hours per night _____ Naps number and length _____ problems? _____

Oral Motor

Age of transition from nursing: Age of transition from bottle to open cup/straw _____
Age of eating solid food: _____ Feeding self from spoon: _____
Use a pacifier No ◯ Yes ◯ Age when stopped: _____

Suck thumb and/or fingers No◯ Yes◯ Age when stopped: _____
Age of first dental visit_____ drooling other than teeth cutting No◯ Yes ◯

Speech and Language:

Did your child vocalize (cry, coo, babble) normally as an infant? Yes ◯ No◯

Language Milestone	Age observed	Example
Reduplicated babbling: ba-ba-ba		
Variegated babbling ba-da-ga		
Jargon words – nonsense sounding sentences		
First meaningful words other than mama and dada		
Two-word combinations		
Three word combinations		

Estimate the size of receptive vocabulary (number of words child understands) _____
Estimate the size of expressive vocabulary (number of words child spontaneously uses) _____
Does the child use correct word order (grammar) used in sentences/phrases? Yes◯ No ◯
How well does your child understand what is being said to him/her? (ability to follow directions and understand meaning of words) _____
What is the current communication style(s) used by your child? (check all you have seen your child perform)

- ☐ Non-word vocalizations_____
- ☐ Gestures and/or pointing_____
- ☐ Words and gestures_____
- ☐ Single words_____
- ☐ Two -word combinations_____
- ☐ Short phrases_____
- ☐ Full Sentences _____
- ☐ Other _____

What percent of your child's speech do you (parents) easily understand? 25 %◯ 50%◯ 80%◯ 100%◯
What percent of your child's speech do those outside of the family easily understand? 50%◯ 80%◯ 100%◯
Do you feel your child is delayed in any areas such as social, motor, learning, feeding?
Yes ◯ No◯
If yes, please explain: _____

EDUCATION:
Is your child enrolled in any type of childcare facility, preschool program? No ◯ Yes◯
Is your child enrolled in public or private school? No◯ Yes◯
Name of School/Facility: _____ Date enrolled: _____
Hours enrolled per week:_____ Current grade level: _____
Performance level: Average ◯ Below Average ◯ Above Average◯
Teacher's Impressions: _____

Do you agree ____◯____/disagree? ___◯___
Describe any special assistance or help provided in the educational setting:
_____

BEHAVIOR and PERSONALITY:
Please check characteristics which best describe your child:

_☐_Shy _☐_Social/Outgoing _☐_Overactive _☐_Impulsive_☐_Affectionate _☐_High strung _☐_Tantrum prone
_☐_Inattentive_☐_Excessively talkative _☐_Quiet _☐_Perseverates (get stuck) on thoughts/ideas_☐_Demanding
_☐_Stubborn _☐_Indiscriminately friendly_☐_Attention seeking _☐_Difficulty separating from parent
_☐_Excessively moody_☐_Responds positively when praised _☐_Respond poorly when criticized_☐_Other
Does your child display any behaviors that concern you? No _◯_Yes_◯_
If yes, please describe: _____
Strengths:
_☐_Artistic _☐_Good at sports _☐_Cooperative _☐_Insightful_☐_Likes to please _☐_Motivated
_☐_Intelligent _☐_Good with his hands_☐_Gets along great with others (good social skills)
Other (specify):

Preschool/Toddler: Please list your child's preferred toys _____

School Age: Please list your child's preferred activities_____

What motivates your child? (Please list all that applies) _____

Specific Speech Language Related Concerns

Here are some questions or comments of concerns expressed by other parents. Please check all that apply.

- ☐ Why isn't my child talking?
- ☐ Why does my toddler throw food?
- ☐ Will my child start be talking normally?
- ☐ My child isn't very interested in being with ne or other people.
- ☐ My child doesn't seem to listen.
- ☐ My child doesn't seem to understand what I say.
- ☐ My child understands a lot but doesn't talk very much.
- ☐ My child shows little or no interest in toys.
- ☐ My child can't read very well.
- ☐ My baby only wants baby food.
- ☐ I'm not sure whether it's okay to speak two languages at home.
- ☐ My child has a very short attention span.
- ☐ Why does my baby throw up after eating?
- ☐ I'm having a hard time coping with my child's communication difficulties.

List any additional information that you feel is important for the speech language pathologist to know (e.g., child's most pressing difficulties, etc) here or parental concerns: _____

Apple Flats Speech Pathology Clinic LLC

CLINICAL RECORDS RELEASE/REQUEST FORM

Patient Name: _____ Date of birth: _____

(CHECK BOTH)

☐ Release - Releasing information from us to you or your provider

☐ Request - Requesting information from another provider to us

Date: _____/_____/_____

Address _____ City: _____ State: _____ Zip: _____

Phone: _____ Social Security #: _____-_____-_____

I authorize Apple Flats Speech Pathology Clinic LLC to release/request the following information:

☐ Request clinical progress notes/ reports as applicable to patient referral from my child's primary care physician or other relevant physician.

☐ Request clinical progress notes/reports, patient evaluations, and patient worksheet to my child's insurance company, primary care physician, and /or educational institution.

Physician/ School/ Therapy

_____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Patient (or parent if minor) Signature Date

_____

Witness by: Date

Apple Flats Speech Pathology Clinic LLC

ADVANCE DIRECTIVES POLICY

Apple Flats Speech Pathology Services LLC (Bonnie Vest, owner) requires each person receiving treatment in this facility to sign the following notice to comply the Self-Determination Act regard advance directives. In this facility, or any other facility where services are being provided, should a patient suffer a life-threatening situation this signed notice implies agreement on the resuscitation and transfer of the individual to a higher medical care facility. If in the event the person has an Advanced Directive and has provided that to our office, we will honor the patient's directive. Any further concerns regarding this policy should be addressed with your physician.

I have read the above policy and understand the information in the policy.

Printed name of patient

Signature of Patient/Parent of Legal Guardian Date

Signature of Facility Witness Date

Apple Flats Speech Pathology Clinic LLC

Office Policies

Subject: Patient Responsibilities

PURPOSE

To inform the patients of their responsibilities as a participant in the total care process.

POLICY

All patients are responsible for:

1. Assuring that the financial obligations for health care rendered are paid in a timely manner.
2. Accepting consequences of their actions if they should refuse a treatment or procedure, or if they do not follow or understand the instructions given them by the doctor or their health care team member.
3. Providing the Clinic to the best of their knowledge with an accurate and complete medical history about present complaints, past illnesses, hospitalizations, surgeries, and existence of advance directives medications and other pertinent data.
4. Following the plan of treatment recommended by the doctor primarily responsible for the patient's care and/or other personal authorized by the Clinic to instruct patients.
5. Notifying the Clinic of any change in their condition or circumstances.
6. Keeping the appointment for schedule services. If they anticipate a delay or changes, they must cancel the schedules service, it is their responsibility to notify the clinic as soon as possible.
7. The disposition of their valuables while at the Clinic is the responsibility of the patient or the guardian.

COPAYS ARE DUE BEFORE SERVICES ARE RENDERED

REFUNDS FOR CO-PAYS AND MEDICAID AS SECONDARY INSURANCE-
Co-pays paid due to meeting deductibles and Medicaid payments made due to eligibility for Medicaid will be reimbursed as payments for sessions are received by the clinic.

Patient or Parent (if minor): _____Date: _____/_____/_____

Apple Flats Speech Pathology Clinic LLC

In coming to the Speech Language Pathologist, a patient gives the therapist permission and authority to care for the patient in accordance with the evaluation and therapy procedures. The therapist, of course, will not give any treatment or health care if she is aware that such care may be contraindicated. The SLP provides a specialized, non-duplicating health care service. Your therapist is licensed in a special practice and is available to work with other types of providers in your health care plan. This health care plan will be explained and reviewed with you.

The specialized clinicians at Apple Flats Speech Pathology Clinic LLC use treatment rooms for privacy of services provided. All clinicians respect your privacy, so a private room is available for conversations if needed. Assorted notes/therapy information and paperwork might be handed to you to complete your child's therapy session or to provide you with update information. Please be aware of your responsibility to guard these as you see fit while they are in your possession and return them as quickly as possible.

Please sign the following paragraph for services to continue:

I understand that if I am accepted as a patient by a therapist at Apple Flats Speech Pathology Clinic LLC., I am authorizing the therapist to proceed with any treatment that maybe necessary. Furthermore, any risk involved regarding speech, physical, or occupational therapy will be explained to me upon my request. I (PRINT NAME)

_____ authorize Apple Flats Speech Pathology Clinic LLC to evaluate

and/or provide skilled intervention in Speech, Occupational, Physical Therapy, Nutrition Counseling, and/or Developmental interventions.

Acknowledgment of Risk

I understand that there is some risk inherent in the use of therapeutic equipment at this clinic, and I agree to indemnify and hold the clinic harmless for any and all losses and claims for any injuries occurring to my child or myself from the use of therapeutic equipment.

INITIAL_____

Coordination of Care

I give permission for this clinic to send copies of progress reports to all referral sources whose names I have provided.

INITIAL _____

Photographs/Videotapes

I give permission for photographs/videotapes to be taken of myself, or my child for therapy documentation, educational and/or promotional purposes.

INITIAL _____

Signature: _____ Date: _____

HIPPAA Privacy Compliance Manual

APPLE FLATS SPEECH PATHOLOGY CLINIC LLC

PATIENT INFORMATION & FINANCIAL AUTHORIZATION

PLEASE BE PREPARED TO PRESENT INSURANCE CARD (S) AND A DRIVERS LICENSE

Patient Name: _____Date of Birth_____

Address: _____ Gender: Male _____ Female _____

Phone: Home: _____ Patient Social Security # _____

Cell: _____ Patient: Single ◯ Married ◯

Work: _____ Dependent ◯

E-Mail: _____

Name of Insurance_____

Policy or Group # _____

Insurance Phone: _____

Name of primary insured: _____ Relationship to patient _____

Employer: _____ Employer Phone: _____

Employer Address: _____

Parent/Guardian Name _____ Date of birth: _____

Social Security Number #_____ Drivers' License # State: _____

Spouse Name: _____ Date of birth: _____

Social Security Number # _____ Drivers' License # State: _____

Secondary Insurance: _____ Name of secondary insured: _____

Relationship to patient: _____ Employer: _____

Employer phone: _____ Employer Address: _____

IN CASE OF EMERGENCY

Notify _____Phone: _____Relationship to patient: _____

Name of nearest relative: _____Phone: _____

Address: _____