

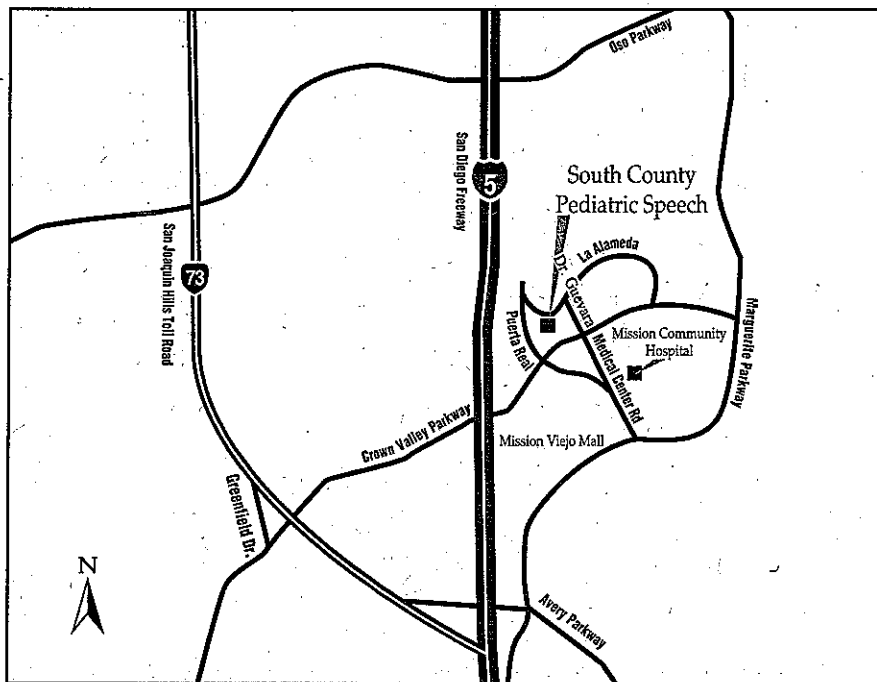
South County PEDIATRIC Speech

Appointment Date: _____ **Time:** _____

Please complete and sign the enclosed paperwork and bring it with you to your appointment.

If you have any questions please feel free to contact your therapist at 949.367.8150.

Thank you very much. We look forward to meeting you!



From the 5 Freeway:
Exit Crown Valley Pkwy. towards
Mission Viejo. Turn Left at Dr. Guevara.
Turn Left at La Alameda. We are the
second building on the left. Make a Left
between the first and second buildings
and park behind the second building.

From the 73(S) Freeway/Toll Road: Exit
Greenfield Drive and turn Right. Proceed
to Crown Valley Pkwy. and turn Left.
Continue North and turn Left at
Dr. Guevara. Turn left at La Alameda.
We are the second building on the left.
Make a Left between the first and second
building and park behind the second
building.

South County PEDIATRIC Speech

Dear Parents,

Welcome to South County Pediatric Speech. We would like to extend our gratitude to you for choosing us to assist in the development of your child's speech and language. Our goal is to work cooperatively with you, so that together, we can enhance your child's communication skills. We aim to provide outstanding services to your child, by offering a nurturing, stimulating, and rewarding environment. In order to help us provide quality service, please take note of our policies.

- An appointment time will be reserved specifically for your child. To achieve the maximum benefit of therapy, we encourage you to maintain a consistent schedule. Appointments that need to be cancelled **MUST BE DONE BEFORE 9:00 a.m.** the day of the appointment. Appointments cancelled after 9:00 a.m. the day of the scheduled appointment will result in a **LATE CANCELLATION CHARGE**. Failure to cancel an appointment will result in a **FAILED APPOINTMENT CHARGE**. If a failed appointment or late cancellation of an appointment is **NOT** rescheduled within **two weeks**, you will be charged for the failed or late cancelled appointment. Inconsistent attendance (for reasons other than illness) will result in your child being placed on a waiting list or reduced to a more manageable and convenient therapy schedule.
- Speech pathology services are provided for your child with the understanding that payment for such services is the responsibility of the parent or guardian. Payment for services rendered is due at the time of service. Charges are as follows:

Speech and Language Therapy	
1 hour session	\$120.00
30 min session	\$65.00

- South County Pediatric Speech is not a preferred provider with any insurance companies and does not bill insurance directly. We will, however, assist you in receiving the maximum allowable benefits from your insurance company. At your request, you will be provided with a statement containing the information required by most insurance companies. Since the scope of benefits can vary among insurance plans, you are encouraged to check with your insurance company regarding coverage. We make no express or implied representation that your insurance will recognize speech and language services as an allowed benefit to you.
- If reports are required by insurance, school district, or other persons, a report writing fee of \$250.00 will be charged.
- South County Pediatric Speech believes in your right to privacy and will not release any personal information to outside parties without your consent and knowledge.
- If you take time off from treatment, for more than two weeks, you can either: 1) Pay the regular treatment rate to reserve your treatment time and therapist beginning the

3rd week of your absence; or 2) relinquish your treatment time beginning the 3rd week of your absence, with no guarantee of getting the same slot and/or therapist.

- You are required to give two weeks notice before discontinuing treatment. This will allow closure for your child, as well as ample time for the therapist to complete any testing that may need to be done prior to discharge.
- If your child is receiving Oral Motor Therapy, you will be provided with one set of oral motor materials at no cost. If materials need to be replaced or if you request a second set of materials, you will be billed the cost of additional therapy items.
- In consideration of other patients and therapists, as well as for the comfort of your own child, please do not bring children to therapy when they are ill.
- For the safety of your child, we require that you accompany your child to the restroom. Additionally, please do not allow children to run about the building, whether they are in direct eyesight or not. The management has attempted to make the grounds more appealing, and requests that children do not climb on rocks or trample through flower beds. We must respect the other tenants of the building and remember that they are working.
- Please help us keep the waiting room clean. Many children and adults use this area throughout the day, and your help in putting away books is greatly appreciated. There is also **NO FOOD OR DRINKS** allowed in the waiting room. Please consume any food or beverages outside.
- When contacting South County Pediatric Speech please be sure to use our main line: 949.367.8150 to reach therapists and/or access our voice mail system. Though our back line numbers may appear on your cell phones when we make outgoing calls, please do not use these numbers to return our calls. These back lines have no access to our voice mail system and therefore, the telephone will continually ring, thus disrupting treatment.
- We encourage parent participation during therapy. If for any reason you are not able to stay during your child's treatment, we understand. For children wearing diapers, we request that you contribute a diaper and change of clothes in case of an emergency. We will store your child's diaper and clothing in the kitchen area.

If at any time you have questions, need assistance, would like to discuss your child's progress, or seek additional services or resources, please do not hesitate to talk with us. If for any reason you need to file a formal grievance regarding a therapist or office policy, we ask that you do so in writing. Your grievance will be addressed in a timely manner.

We welcome your suggestions on how we can work as a team to keep South County Pediatric Speech a pleasant learning environment for all. Your cooperation is greatly appreciated; thank you for your continued support of our business!

Sincerely,

Miché Lano Almeida

Janine M. Murdock

I have read and agree to the policies regarding attendance and payment for services rendered.

Parent Signature

Date

INITIAL VISIT AND REPORT FEES

South County Pediatric Speech offers consultations and evaluations to meet your speech and language child's needs.

Consultation: A consultation refers to a review of your child's previous reports, informal observation of your child, and formalized testing. A consultation is offered for **articulation assessment only, language assessment only, and comprehensive speech and language assessment for children birth to three years of age.** There are no reports provided with a consultative appointment. Fees are \$250 for one hour. Should a written report be required at a later date, an additional \$250 report-writing fee will be charged.

Articulation assessment only: Includes the review of records and previous reports, meeting with the child for one hour, administration of informal and formal articulation measures, an oral-motor exam. *(If your child has difficulties with articulation as well as language, you will want to schedule a comprehensive speech and language assessment.)*

Language assessment only: Includes the review of records and previous reports, meeting with the child for one hour, administration of informal and formal language tests, scoring and interpretation of tests.

Comprehensive speech and language assessment for children birth through 36 months: Includes review of previous records and patient history, meeting with the child for approximately one hour, parent interview, administration of informal and formal tests, scoring and interpretation of tests.

Comprehensive speech and language evaluation: (ages 3 years and up) Includes the review of previous records and patient history, meeting with the child for approximately one to two hours, administration of informal and formal tests, language sample and analysis (if necessary), written report including recommended goals and course of treatment; and review of report with parent(s). The fee for the comprehensive speech and language evaluation is \$250.00 for the first hour, with an additional \$120.00 for each additional hour of testing necessary, as well as \$250 for a report-writing fee.

Reports are often required by insurance companies in order to authorize services. We recommend that you check with your insurance company before scheduling an initial visit.

I have read, understand and agree with the policies described above.

Signature

Date

Policy Regarding Cancellations

An appointment time will be reserved specifically for your child. To achieve the maximum benefit of treatment, we encourage you to maintain a consistent schedule. Appointments that need to be cancelled must be done so before 9:00a.m. the day of the appointment. Failure to cancel the appointment prior to 9:00a.m. the day of the scheduled appointment will result in a late cancellation charge. A late cancellation charge is billed directly to you at the regular rate of a treatment session. In addition, failed appointments also result in a failed appointment charge. It is also billed directly to you at the regular rate of a treatment session. If a failed appointment or late cancellation of an appointment is rescheduled within two weeks, you will be charged for the rescheduled appointment only. Cancellation of appointments prior to 9:00 a.m. enables the therapist to schedule other clients in your time slot for that day.

Inconsistent attendance (for reasons other than illness) will result in your child being placed on a waiting list or reduced to a more manageable and convenient treatment schedule.

I have read and understand the cancellation policy at South County Pediatric Speech. In compliance with the policies regarding cancellation and payment, I agree to have South County Pediatric Speech keep my credit card information on file only to be used with my explicit permission or at the discretion of South County Pediatric Speech in the event that I discontinue services prior to reconciling any outstanding balances.

Parent Signature

Date

Credit Card #: _____

Expiration Date: _____

South County PEDIATRIC Speech

PEDIATRIC CASE HISTORY

Child's Name _____

Birthdate _____ Age _____ Male Female

Address _____

Telephone () _____

Referred by _____ Phone () _____

Reason for Referral _____

Father's Name _____ Birthdate _____

Employer _____ Phone () _____

Mother's Name _____ Birthdate _____

Employer _____ Phone () _____

Marital Status _____

Other Persons Living in Home

Name	Relationship	Age

Is any language other than English spoken in the home? Yes No

If "Yes", what other languages are spoken? _____

What language do you consider to be the primary language? _____

Is there a family history (parents, brothers, sisters, aunts, uncles, cousins, grandparents) of any of the following?

	Family Member		Family Member
Hearing Loss	_____	Alcoholism	_____
Speech Problem	_____	Drug Use	_____
Prematurity	_____	Mental Illness	_____
Low Birth Weight	_____	Delayed Motor	_____
Syndromes	_____	Development	_____
Cleft Lip/Palate	_____	Educational	_____
Seizure Disorder	_____	Difficulties	_____
Blindness	_____	Other	_____

Describe in your own words the nature of your concerns about your child's development.

Has your child been given a diagnosis of any kind? Diagnosis: _____

If so, list when and by whom. _____

Has your child received any previous treatment for this problem? Yes No

If "Yes," where? _____

Prenatal and Birth History

Please check any that applied during pregnancy.

_____ excessive vomiting	_____ drug use
_____ hemorrhaging	_____ alcohol use
_____ illnesses (i.e., German Measles)	_____ excessive weight loss
_____ RH incompatibility	_____ excessive weight gain
_____ premature rupture of membranes	_____ smoking
_____ diabetes	_____ X-ray treatments
_____ high blood pressure	_____ trauma/injuries
_____ hospitalization / bed rest	_____ previous miscarriages
_____ medications taken	_____

How long was the pregnancy / labor? pregnancy _____ labor _____

Was the birth by Cesarean Section? Yes No (Elective / Emergency)

Were there any complications during labor? Yes No

If "Yes," please explain? _____

Were there any complications following delivery? Yes No

If "Yes," please explain? _____

Birth Weight _____ Apgar Scores _____

How many days did your child remain in the hospital? _____

If any of the following illnesses apply to your child, please list the date when occurred.

_____ Tonsillitis	_____ Sore Throat	_____ Ear Problems
_____ Measles	_____ Allergies	_____ Hearing Loss
_____ Mumps	_____ Asthma	_____ Ear Surgery
_____ Chicken Pox	_____ Coughing	_____ Surgery
_____ Influenza	_____ Hoarseness	_____ Adenoidectomy
_____ High Fever	_____ Breathing Difficulty	_____ Tonsillectomy
_____ Pneumonia	_____ Swallowing Difficulty	_____ Thyroid Disorder
_____ Meningitis	_____ Dizzy Spells	_____ Dental Problems
_____ Encephalitis	_____ Blackouts	_____ Vision Problems
_____ Headaches	_____ Seizures	_____ Stuttering
_____ Frequent Colds	_____ Poor Memory	_____ Head Injury

Is your child currently taking any medications? Yes No

If "Yes," please list. _____

Developmental History

At approximately what age did your child achieve the following motor milestones?

_____ sitting alone	_____ eating finger foods
_____ crawling	_____ eating with a spoon
_____ standing alone	_____ undressing
_____ walking alone	_____ potty training

Does your child appear awkward or clumsy? Yes No

Which hand does your child prefer to use? Left Right

Does your child have any physical handicaps? Yes No

If "Yes," please list. _____

Has your child had any feeding difficulties? Yes No

_____ sucking or nursing
_____ excessive length of time to drink bottle
_____ regurgitation of liquids or solids through nose
_____ difficulty chewing or swallowing meats
_____ choking and / or gagging
_____ other _____

Was your child breast / bottle fed? Breast Bottle

Age weaned _____

Age weaned _____

Does your child drink from a cup? Yes No

Can your child use a straw? Yes No

Does/Did your child drool more than children his/her age? Yes No

Does/Did your child suck his/her thumb/fingers? Yes No

Does/Did your child use a pacifier? Yes No

Does/Did your child mouth breath? Yes No

Does/Did your child grind his/her teeth? Yes No

Hearing History

Has your child's hearing ever been tested?

Yes

No

Where _____

When _____

By Whom _____

Results _____

Recommendations _____

Has your child had any ear infections?

Yes

No

How many episodes? _____

If "Yes", at what age did the infection(s) first occur? _____

What was the duration of the infection(s)? _____

How was the infection(s) treated?

antibiotics

surgery

Which antibiotics have been used to treat the infection(s)? _____

Does your child wear hearing aids?

Yes

No

Left

Right

If "Yes", what type / brand? _____

Speech and Language Development

Please indicate when your child first demonstrated the following.

_____ cooing, pleasure sounds

_____ babbling (ma-ma, da-da)

_____ jargon (talking in own special language)

_____ single words

_____ phrases (mommy bye-bye)

_____ short sentences

What is the primary method(s) your child uses for letting you know what s/he wants?

_____ looking at objects

_____ crying

_____ pointing at objects

_____ physical manipulation

_____ gesturing/signing

_____ vocalizing

_____ using single words

_____ using 2-3 words

_____ using sentences

Is your child's speech difficult to understand?

Yes

No

If "Yes", please explain. _____

Does your child have difficulty producing certain sounds?

Yes

No

If "Yes", which ones? _____

Does your child hesitate and/or repeat sounds or words?

Yes

No

Do you have concerns about your child's voice?

Yes

No

Which of the following do you think your child understands?

_____ his/her own name

_____ names of family members

_____ names of body parts

_____ simple directions

_____ complex directions

_____ conversational speech

Does your child appear to have a short attention span?

Yes

No

Educational History

Educational Setting	Location/School	Days/Hours of Attendance
Birth to 3 Program		
Preschool Program		
Grade School		

Has your child ever been evaluated or received treatment for:

_____ speech/language problems

_____ feeding problems

_____ hearing problems

_____ fine motor problems

_____ vision problems

_____ gross motor problems

_____ other _____

Please give locations, dates and results for any evaluations.

Evaluation	Date	Location/Provider	Results

Please list number of days/hours of services your child receives per week.

(OT, PT, hydro, visual, etc.)

Therapy	# of Days	Hours	Location/Provider

Pediatrician

Pediatrician _____

Address _____

Phone () _____

Would you like your pediatrician to receive a copy of the evaluation report?

Yes

No

Please provide the names, addresses, and telephone numbers of any other persons you would like to receive a copy of the evaluation report.

Name _____

Name _____

Address _____

Address _____

Phone () _____

Phone () _____

South County PEDIATRIC Speech

South County Pediatric Speech would like to develop and maintain a connection with other medical, therapeutic and educational professionals on behalf of your child. Please provide the names and numbers, if applicable, of any of the following professionals. Thank you!

Pediatrician:	Number:
Neurologist:	Number:
Dentist:	Number:
Orthodontist	Number:
Occupational Therapist:	Number:
Physical Therapist:	Number:
Preschool/Daycare:	Number:
School:	Number:
Other:	Number:

South County **PEDIATRIC** Speech

NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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.

South County Pediatric Speech is committed to protecting your privacy and understands the importance of safeguarding your personal health information. We are required by federal law to maintain the privacy of health information that identifies you or that could be used to identify you (known as "Protected Health Information" or "PHI"). We are also required to provide you with this Notice, which explains our legal duties and privacy practices with respect to PHI that we collect and maintain. This Notice describes your rights under federal law and state law, where applicable, relating to your PHI. South County Pediatric Speech is required by federal law to abide by this Notice. However, we reserve the right to change the privacy practices outlined in this Notice and make the new practices effective for all PHI that we maintain. Should we make such a change, we will display the revised Notice at our office and make it available to you upon request.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Routine Uses and Disclosures of Protected Health Information For Treatment, Payment, or Health Care Operations

South County Pediatric Speech is permitted under federal law to use and disclose PHI without your specific permission for three types of routine purposes: treatment, payment and health care operations.

Set out below are examples of the uses and disclosures of your PHI we are permitted to make for these routine purposes. While this list is not meant to be exhaustive, it should give you an idea of the everyday uses and disclosures that are essential to the care you receive.

Treatment. Your PHI can be used and disclosed by South County Pediatric Speech for treatment purposes. For example, your therapist will use your PHI to counsel you about your child's treatment options.

We may also use and disclose your PHI to provide you with information regarding possible alternative treatment options and other health-related benefits and services that we believe might interest you. For example, we may refer you to other professionals such as audiologists, pediatricians or occupational therapists.

Payment. Your PHI can be used and disclosed for payment purposes. For example, we may communicate your PHI to your insurance company so that it can process payment for your treatment. However, it is the policy of South County Pediatric Speech that only the diagnostic codes that you wish revealed be provided to the insurance company.

Health Care Operations. Your PHI can be used and disclosed to allow us to conduct health care operations, which generally are the administrative activities that we undertake in order to operate our facility. For example, we may use your PHI to evaluate the performance of our therapist and to engage in other quality assurance activities.

Other Uses and Disclosures of PHI We May Make Without Your Authorization

In general, we are required to obtain your specific written authorization to use or disclose your Protected health Information for purposes unrelated to treatment, payment, or health care operations. However, there are exceptions to this general rule under which we are permitted or required to make certain uses and disclosures of your PHI without authorization. These situations include requirements by:

The Secretary of Health and Human Services for investigative purposes; Public Health authorities; Abuse or Neglect Agencies if you have been a victim of abuse, neglect or domestic violence; Health Oversight Agencies for the purposes of investigations, inspections, licensure or disciplinary actions; Judicial and Administrative Proceedings in response to court or agency orders or subpoenas; Law Enforcement Agencies for law enforcement purposes; Coroners, Medical Examiners and Funeral Directors if needed to carry out their duties; Researchers conducting research under established protocols; Specialized Government Functions for purposes related to military or national security concerns; and Workers' Compensation Agencies in order to comply with workers' compensation laws. Your PHI may also be disclosed if we believe it is necessary to prevent a serious and imminent threat to the public health or safety and it is to someone we reasonably believe is able to prevent or lessen the threat.

Other Uses and Disclosures of PHI Based Upon Your Written Authorization

Other uses and disclosures of your PHI, not described above, will be made only with your written authorization. You may revoke this authorization at any time, in writing, except to the extent that we have taken action in reliance on the authorization.

YOUR RIGHTS

As a patient, you have certain rights regarding your PHI. We may ask that you submit a written request to exercise your patient rights. These rights include:

You have the right to request a restriction on certain uses and disclosures of your PHI. This means that you may ask us not to use or disclose any part of your PHI for purposes of treatment, payment, or health care operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restriction requested and state to whom you want the restriction to apply. South County Pediatric Speech is not required to agree to such a restriction. If we do agree, we will abide by your restriction unless we need to use your PHI to provide emergency treatment. In addition, we may elect to terminate the restriction at any time.

You have the right to request to receive information from us by an alternative means or at an alternative location if you believe it would enhance your privacy. For example, you may request that your therapist discuss your therapy sessions in the privacy of your therapist's office. We will attempt to accommodate all reasonable requests and will not request an explanation from you as to the basis for your request.

You have the right to inspect and copy your PHI. If you would like to see or copy your Protected Health Information, we are required to provide you access to your PHI for inspection and copying within 30 days after receipt of your request. We may charge you a reasonable fee to cover duplicating costs. In addition, there may be situations where we may decide to deny your request for access. For example, we may deny your request if we believe the disclosure will endanger your life or health or that of another person. Depending on the circumstances of the denial, you may have a right to have this decision reviewed.

You have the right to amend your PHI. This means you may request an amendment of your PHI in our records for as long as we maintain this information. We will respond to your request within 60 days. We may deny your request if, for example, we determine that your PHI is accurate and complete. If we deny your request, we will send you a written explanation and allow you to submit a written statement of disagreement.

You have the right to receive an accounting of certain disclosures we have made of your PHI. You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for treatment, payment, or health care operations. Your request must be made in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003 (the compliance date for the federal regulation) nor for a period of time greater than six years. We are required to provide the accounting within 60 days and to provide one accounting free of charge in any 12-month period. For more frequent requests, a reasonable fee may be charged.

You have the right to file a complaint. If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our office manager or directly to the Secretary of Health and Human Services. To file a complaint with our manager, you must submit it in writing within 180 days of the suspected violation. Provide as much detail as possible about the suspected violation and send it to South County Pediatric Speech. There shall be no retaliation for the filing of complaints.

You have the right to obtain a paper copy of this notice from South County Pediatric Speech.

This notice is effective May 15, 2003.

I have read and understand my rights as outlined in the above notice.

Signature

Date

South County PEDIATRIC Speech

CONSENT FOR RELEASE OF INFORMATION

I hereby give my consent to allow the release of information and/or records/reports regarding:

Name

First

Middle

Last

Birthdate

To

Name

Address

Phone

Name

Address

Phone

Name

Address

Phone

From

South County Pediatric Speech

26400 La Alameda, Suite 107, Mission Viejo, CA 92691

(949) 367-8150 Phone / (949) 367-8154 Fax

Parent/Guardian Signature

Relationship to Child

Date