

## New Patient Intake Form

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Referred by Doctor/Professional (if applicable): \_\_\_\_\_

Diagnosis (if applicable): \_\_\_\_\_

Primary Area of Concern and Describe concern (feeding, speech, language, play, etc.): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Family Information:

Parent/Guardian Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Primary Address of Patient: \_\_\_\_\_

Primary Phone Number: \_\_\_\_\_ Type: Cell    Work    Home

Secondary Phone Number: \_\_\_\_\_ Type: Cell    Work    Home

Primary Email Address: \_\_\_\_\_ Type: Personal    Work

Secondary Email Address: \_\_\_\_\_ Type: Personal    Work

Who will be the primary person bringing your child into therapy? \_\_\_\_\_

What are your preferred days and/or times for making appointments? \_\_\_\_\_

\_\_\_\_\_

\*\*Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

Insurance Information:

Will you be seeking reimbursement from insurance (circle)?  
 If yes, please provide your insurance providers' information:

Yes                      No

Provider: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Primary on Account: \_\_\_\_\_

Group Number: \_\_\_\_\_

Primary on Account Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Secondary Insurance (if applicable):

Provider: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Primary on Account: \_\_\_\_\_

Group Number: \_\_\_\_\_

Primary on Account Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

**EVALUATION QUESTIONNAIRE**

Childs Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Referring Physicians Name (if applicable): \_\_\_\_\_

**GENERAL QUESTIONS**

What are your main concerns for today's evaluation? (fine motor skills, gross motor skills, speech or language skills, feeding concerns, etc.) Please describe: \_\_\_\_\_  
 \_\_\_\_\_

What other services does your child currently receive or has received in the past? (school-based services, Occupational Therapy, Speech Therapy, Physical Therapy, Music Therapy, etc.): \_\_\_\_\_  
 \_\_\_\_\_

Frequency? (daily, weekly, bi-weekly): \_\_\_\_\_  
 If they are in school, what school do they attend?: \_\_\_\_\_

Does your child receive any services from a specialist? (neurologist, endocrinologist, plastic surgeon, ENT, geneticist, optometrist, ophthalmologist, audiologist, orthopedic surgeon, developmental pediatrician):  
 \_\_\_\_\_  
 \_\_\_\_\_

Has your child received services from any of the following state funded agencies? (Circle all that apply)  
 AzEIP DDD CRS ASDB CPS Other: \_\_\_\_\_

Is your child a ward of the state? Yes No Are you the foster parent? Yes No  
 Was your child adopted? Yes No Age at time of adoption: \_\_\_\_\_  
 If you have any other children, how many and what are their ages? \_\_\_\_\_

**BACKGROUND HISTORY**

I. Pregnancy History:

Prenatal Care?	Yes	No	Infections?	Yes	No
Gestational Diabetes?	Yes	No	Toxemia?	Yes	No
Excessive weight gain?	Yes	No	Seizure disorder?	Yes	No
Limited weight gain?	Yes	No	Multiple birth?	Yes	No
Maternal medications?	Yes	No	Pre-term labor?	Yes	No
Maternal alcohol/drug use?	Yes	No	Length of Pregnancy: _____ weeks		

Other Complications: \_\_\_\_\_

II. Delivery:

Difficult Birth?	Yes	No	Baby under respiratory distress?	Yes	No
Prolonged labor?	Yes	No	Oxygen needed for child?	Yes	No
Breech birth?	Yes	No	Baby treated for jaundice?	Yes	No
Cesarean section?	Yes	No	Umbilical cord around baby's neck?	Yes	No
Umbilical cord knot?	Yes	No			
Birth weight: _____			Days in hospital after birth: _____		
Comments: _____					

III. Newborn/Nursery:

NICU stay?	Yes	No	If yes, how long?: _____		
Breathing difficulties?	Yes	No			
Sucking difficulties?	Yes	No	Brain Bleed?	Yes	No
If Yes, what Grade:	I	II	III	IV	Was it resolved?
Newborn hearing screening?	pass		refer		Yes
Comments: _____					

IV. Infancy:

Difficulty sleeping?	Yes	No	Difficulty hearing?	Yes	No
Grunting?	Yes	No	Diarrhea?	Yes	No
Excessive crying?	Yes	No	Vision difficulties?	Yes	No
Comments: _____					

**MEDICAL HISTORY**

Asthma/RAD?	Yes	No	Chronic ear infections?	Yes	No
Seizure disorder?	Yes	No	Heart problems?	Yes	No
Brain Injury?	Yes	No	Encephalitis/Meningitis?	Yes	No
Cerebral Palsy?	Yes	No	High fevers?	Yes	No
Pneumonia?	Yes	No	Lung Problems?	Yes	No
Failure to Thrive?	Yes	No	Chromosomal Abnormalities?	Yes	No
Cleft Lip/Palate?	Yes	No			
Injuries?	Yes	No	Please specify: _____		
Surgeries?	Yes	No	Please specify: _____		
Hospitalizations?	Yes	No	Please specify: _____		
Allergies?	Yes	No	Please specify: _____		
Comments: _____					
Any Medications (note if used daily or as needed): _____					

**FAMILY HISTORY**

Has any immediate or extended family member experienced the following:

Speech/language difficulties	Yes	No	Comments: _____
Hearing difficulties	Yes	No	Comments: _____
Learning difficulties	Yes	No	Comments: _____
Retardation	Yes	No	Comments: _____
Seizure disorder	Yes	No	Comments: _____
Congenital/Genetic Disorder	Yes	No	Comments: _____
Autism Spectrum Disorder	Yes	No	Comments: _____

**OVERALL DEVELOPMENT QUESTIONS**

Please specify the age at which your child acquired specific milestones (months or years):

**Gross Motor History**

- At what age did your child roll over? \_\_\_\_\_
- At what age did your child sit alone? \_\_\_\_\_
- At what age did your child crawl? \_\_\_\_\_
- At what age did your child pull to stand? \_\_\_\_\_
- At what age did your child walk alone? \_\_\_\_\_

**Fine Motor/Self Help History**

- At what age did your child grasp objects? \_\_\_\_\_
- At what age did your child transfer objects between hands? \_\_\_\_\_
- At what age did your child use pincer grasp (thumb & index)? \_\_\_\_\_
- At what age did your child point with index finger? \_\_\_\_\_
- At what age did your child remove clothing? \_\_\_\_\_
- At what age did your child put on clothing? \_\_\_\_\_
- At what age did your child hold a pencil/scissors? \_\_\_\_\_
- At what age did your child show independent toileting skills? \_\_\_\_\_
- At what age did your child show independent dressing skills? \_\_\_\_\_

**Speech/Language History**

Please circle appropriate answer, and provide ages if answered 'No' to questions:

- Cooed, babbled, or imitate sounds as an infant? Yes No If no, age achieved: \_\_\_\_\_
- Used first words by 12 months? Yes No If no, age achieved: \_\_\_\_\_
- Followed 1-step directions by 18 months? Yes No If no, age achieved: \_\_\_\_\_
- Used two word combinations by 2 years? Yes No If no, age achieved: \_\_\_\_\_
- Listened to simple stories by 2 years? Yes No If no, age achieved: \_\_\_\_\_
- Answered simple questions by 2 ½ years? Yes No If no, age achieved: \_\_\_\_\_
- Used simple sentences by 3 years? Yes No If no, age achieved: \_\_\_\_\_

**Speech/Language History Continued**

Is communication for your child frustrating?      Yes      No      Comments: \_\_\_\_\_  
 Is your child hard to understand?                      Yes      No      Comments: \_\_\_\_\_  
 Are certain sounds difficult for your child to say?    Yes      No      Comments: \_\_\_\_\_  
 Is your child bilingual?                                    Yes      No      Comments: \_\_\_\_\_  
 What language(s) are spoken in your home? \_\_\_\_\_  
 What is the primary language used for communicating with your child? \_\_\_\_\_  
 How has your child's speech/language skills progressed over the past 3 months? \_\_\_\_\_

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**Feeding History**

Does your child eat a variety of foods?                      Yes      No  
 Does your child feed him/herself?                              Yes      No  
 Does your child drink from a cup?                              Yes      No  
 Does your child use a straw?                                      Yes      No  
 Does your child eat with a spoon/fork?                      Yes      No  
 Comments: \_\_\_\_\_

**Behavioral History: Does your child present with...**

Attention problems?                      Yes      No      Comments: \_\_\_\_\_  
 Hyperactivity?                              Yes      No      Comments: \_\_\_\_\_  
 Temper Tantrums?                        Yes      No      Comments: \_\_\_\_\_  
 Shy/Withdrawn behavior?              Yes      No      Comments: \_\_\_\_\_  
 Poor eye contact?                        Yes      No      Comments: \_\_\_\_\_  
 Disruptive behavior?                    Yes      No      Comments: \_\_\_\_\_  
 Immature for age?                        Yes      No      Comments: \_\_\_\_\_  
 Sleeping problems?                      Yes      No      Comments: \_\_\_\_\_  
 Disinterest in other children their age?    Yes      No      Comments: \_\_\_\_\_  
 Difficulty getting along with peers?      Yes      No      Comments: \_\_\_\_\_

**Vision/Hearing History**

Do you have any concerns with your child's hearing?      Yes      No  
 Has your child had a formal hearing evaluation?              Yes      No      Results: \_\_\_\_\_  
 Do you have any concerns with your child's vision?        Yes      No  
 Has your child had a formal vision evaluation?              Yes      No      Results: \_\_\_\_\_

Additional Comments/Concerns/Questions: \_\_\_\_\_

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## FEEDING EVALUATION SUPPLEMENTAL QUESTIONNAIRE

**Medical History:**

1. Does your family have a history of feeding/swallowing difficulties?    Yes                      No  
 Comment: \_\_\_\_\_

2. Please provide specialists and their contact information that your child sees (e.g. GI specialist, pulmonologist, ENT, etc.): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

3. Describe any dental problems your child has had: \_\_\_\_\_  
 \_\_\_\_\_  
 Does your child let you brush their teeth?    Yes        No  
 Difficulties? \_\_\_\_\_

4. Describe any respiratory problems and treatments provided if needed (pneumonia, bronchitis, asthma, noisy breathing): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

5. Does your child have a history of the following (please circle):

Tracheostomy	Yes	No	Comment: _____
Oxygen supplementation	Yes	No	Comment: _____
G-tube	Yes	No	Comment: _____
NG-tube	Yes	No	Comment: _____
Pneumonia	Yes	No	Comment: _____
Other respiratory infections	Yes	No	Comment: _____
Gastric Reflux	Yes	No	Comment: _____
Allergies	Yes	No	List/Comment: _____

6. Has your child received any of the following procedures (please circle):

Endoscopy	Yes	No	Date/Results: _____
pH Probe	Yes	No	Date/Results: _____
Upper GI	Yes	No	Date/Results: _____
Allergy testing	Yes	No	Date/Results: _____
Modified Barium Swallow Study (MBSS)	Yes	No	Date/Results: _____

7. Has your child had a history of any GI problems? (e.g. diarrhea, vomiting, constipation, gas) Yes    No  
 Please explain: \_\_\_\_\_  
 Does your child indicate that they need to use the restroom, have a wet/dirty diaper? Yes    No

**Background feeding history and current information:**

1. Child's current Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Does this fall within normal ranges on the growth chart for their age/gender?    Yes                      No

2. Was your child breast-fed?    Yes    No    If yes, for how long? \_\_\_\_\_

Did your child have any difficulty with breast-feeding? (poor suck, slow to feed, poor latch)

3. When did child have their first bottle? (Age) \_\_\_\_\_ Nipple used: \_\_\_\_\_

Any trouble with bottle?    Yes    No    Please explain: \_\_\_\_\_

4. When was your child weaned from breast/bottle to cup drinking? (Age) \_\_\_\_\_

Any difficulties moving to cup drinking?    Yes    No    Please explain: \_\_\_\_\_

5. When did they try cereal? (Age) \_\_\_\_\_ When did they try baby food? (Age) \_\_\_\_\_

Any difficulties with spoon feeding cereal or other solids?    Yes    No    Please explain: \_\_\_\_\_

6. Does your child drool while eating?    Yes    No    Comment: \_\_\_\_\_

Does your child drool while drinking/spill liquid? Yes No    Comment: \_\_\_\_\_

Does your child drool while not eating/drinking? Yes No    Comment: \_\_\_\_\_

7. How would you describe your child's appetite? Please circle: Good    Fair    Poor    Variable

Please explain: \_\_\_\_\_

8. Describe a typical meal for your child:

Breakfast:	Lunch:
Dinner:	Snack:

9. How many times a day does your child eat/drink? \_\_\_\_\_

Amount child eats and/or drinks per meal? \_\_\_\_\_

How long between meals? \_\_\_\_\_

How long does each meal take for them to eat? \_\_\_\_\_

Are there any toys at the table? Yes No Comment: \_\_\_\_\_

10. What equipment does your child use to eat? (Please circle): Bottle    Nipple                  Cup    Spoon

11. Does your child self feed?    Yes    No With what? (Please circle)    Fingers    spoon    fork

12. Does child hold bottle, cup without spout, or regular cup independently? (Please circle) Yes                      No



13. Where does your child eat at home? (Please circle)

Table                      High Chair                      Seating device                      Lap                      Booster seat  
 Who feeds your child? (Please circle) Parent                      Caregiver                      Child self-feeds                      Other  
 Does your child participate in meal preparation/clean up? Yes                      No                      Comment: \_\_\_\_\_

14. What consistency does your child eat? (Please circle)

Smooth baby food                      Semi-chunky baby food                      Chunky baby food  
 Mashed table food                      Regular table food                      Other: \_\_\_\_\_  
 Comment: \_\_\_\_\_

15. What kinds of liquids does your child drink? (Please circle) Regular (water/juice)                      Thickened

How thick (pudding, nectar, honey, etc.) and type of thickener?: \_\_\_\_\_  
 If your child drinks milk, what type of milk? (Please circle) Cow's                      Soy                      Breast                      Formula type \_\_\_\_\_  
 \*If nursing, does mother have adequate production of milk? Yes                      No Comment: \_\_\_\_\_  
 Does your child drink juice? Yes                      No                      If yes, how much in 1 day? \_\_\_\_\_  
                     When: before                      after                      during meal

16. What foods are easy for your child to eat? (e.g. baby food, pasta, crunchy foods, soft foods, yogurt, meltable solids, fruits, vegetables, meat, etc.): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

17. What foods are difficult for you child to eat? (e.g. baby food, pasta, crunchy foods, soft foods, yogurt, meltable solids, fruits, vegetables, meat, etc.): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

18. Any behaviors during mealtime? (Please circle)

Crying	Yes	No	Clamping mouth shut	Yes	No
Refusing to eat	Yes	No	Turning head away	Yes	No
Gagging	Yes	No	Verbal refusal (i.e. "I don't want that")	Yes	No
Vomiting	Yes	No	Holding food in mouth	Yes	No
Spitting	Yes	No	Getting down from table	Yes	No
Throwing food/utensils	Yes	No	Tolerate new foods on plate	Yes	No
Touch new foods	Yes	No	Taste new foods	Yes	No
Coughing	Yes	No	Congestion during feeding	Yes	No
Wet/gurgly voice	Yes	No	Food spilling out of mouth	Yes	No

What do you do when these behaviors are displayed? (before/during/after meal) \_\_\_\_\_

Comments: \_\_\_\_\_  
 \_\_\_\_\_

19. Does your child eat the same amount and variety of foods when others are present? Yes  No   
 At school/daycare? Yes  No  Comment: \_\_\_\_\_

20. If your child receives any supplemental feedings, what type? (Please circle)  
           NG    GJ    G-tube   J-tube            PEG    oral supplements (e.g. Pediasure)  
 How much? \_\_\_\_\_

**Sleeping Patterns:**

1. When does your child go to sleep (typical time) \_\_\_\_\_
2. Does your child snore?            Yes    No            Mouth breather when asleep? Yes            No
3. Does your child sleep through the night? Yes            No            If no, please explain: \_\_\_\_\_
4. Take a nap during the day?            Yes    No            When and how long? \_\_\_\_\_
5. Does your child have difficulty falling asleep?            Yes    No            Comment: \_\_\_\_\_
6. Does your child have difficulty staying asleep?            Yes    No            Comment: \_\_\_\_\_
7. What is the time difference between last meal and nap time? \_\_\_\_\_
8. What is the time difference between last meal and bed time? \_\_\_\_\_



## HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU AND/OR YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW ALL POINTS BELOW CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care 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" 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.

**Uses and Disclosures of Protected Health Information:** Your protected health information may be used and disclosed by your physician, therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your healthcare bills, to support the operations of the 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 health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. 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 health care services. For example, obtaining approval/ payment for treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval/ payment for the treatment.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of new employees/staff, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to new therapists/staff that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your treating provider. We may also call you by name in the waiting room when your provider 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 Disease Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation. 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, provider, or the provider's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**YOUR RIGHTS** – 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.

Your physician/ provider is NOT required to agree to a restriction that you may request. If the physician/ provider 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 communication 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 (i.e. electronically).

**You may have the right to have your physician/ provider 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 via 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 your provider of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before June 1, 2014.



## NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT FORM

By signing this form, I acknowledge that I have received a copy of *Eat, Talk & Play Therapy LLC's* Notice of Privacy Practices.

Patient's name: \_\_\_\_\_ DOB: \_\_\_\_\_

Guardian's name: \_\_\_\_\_ (printed)

Relationship to patient: \_\_\_\_\_

Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If we are unable to speak with you directly by phone, is it okay for us to leave detailed/ clinical information on your answering machine, if available?

YES

NO

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### OFFICE USE ONLY

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Comments/Restrictions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**CLIENT BILLING POLICY**

Eat, Talk & Play Therapy LLC is a small business that specializes in the evaluation and treatment of children with speech, language and/or feeding difficulties. Similar to any independent business, my ability to continue to provide treatment to your child is dependent on timely payment for services rendered. I have created this Billing Policy to clearly communicate with you the responsibilities between my business and yourself regarding reimbursement for your child's treatment. ***Please initial each line and sign bottom of form.***

1. Co-payments, co-insurance, and contracted insurance rates (for clients that have not met their annual deductible) will be ***collected at time of service***. Families will be notified of the amount prior to beginning therapy sessions. Payments can be paid via cash, check, or credit card (transaction fee charged via PayPal). **INITIALS:** \_\_\_\_\_

**Returned checks will incur a \$40 return fee.**

2. In the event that your insurance denies payment for services rendered, you are responsible for payment of those services rendered IN FULL within 30 days of the billing invoice, at the contracted rate of the insurance company. **INITIALS:** \_\_\_\_\_

3. Overpayments will be credited to clients while services are being provided. When a client is discharged, or services are ceased, family will be provided with a check of credited amount. **INITIALS:** \_\_\_\_\_

3. CASH rates (clients NOT billing through insurance) are as follows:

Therapy sessions are 45-50 minutes, with 10-15 minutes of time built in for clinician to write notes, prepare for session, contact insurance companies (as needed), and write reports.

Speech-Language Therapy Session **\$80/session** Speech-Language Evaluation= **\$200/evaluation**

Feeding Therapy Session = **\$100/session** Feeding Therapy Evaluation= **\$250/evaluation**

**INITIALS:** \_\_\_\_\_ **or N/A if using insurance:** \_\_\_\_\_

4. An invoice will be provided every month, reflecting the amount that insurance has paid and the amount due for services provided. In the event that payment is not received ***within 15 days***, your credit card will be charged (including transaction fee via PayPal) for amount owed. **INITIALS:** \_\_\_\_\_

***Credit card information is required to have on file.***

Credit Card Information: (Circle) Visa    Mastercard    American Express    Discover

Credit Card Number: \_\_\_\_\_

Exp. Date: (MM/YY) \_\_\_\_\_ Billing Zip Code: \_\_\_\_\_ CVC code: \_\_\_\_\_

***Bill this card (circle):***    ***Always***    ***Only for Insurance***    ***HSA card***

***Email address for receipts:*** \_\_\_\_\_

Alternate credit card

Credit Card Information: (Circle) Visa    Mastercard    American Express    Discover

Credit Card Number: \_\_\_\_\_

Exp. Date: (MM/YY) \_\_\_\_\_ Billing Zip Code: \_\_\_\_\_ CVC code: \_\_\_\_\_

**Bill this card (circle):**    *Always*    *Only for Insurance*    *HSA card*

**Email address for receipts:** \_\_\_\_\_

Prior to initiation of services, Eat, Talk & Play Therapy LLC will contact your insurance provider regarding your plan’s deductible, co-payments, and expected payments to be made during ongoing therapy sessions. We do our best to get the most accurate and detailed information, however it is **YOUR** responsibility as the insurance policy holder to understand your insurance plan and exclusions. It is your responsibility as an insurance policy holder to pay healthcare providers for services rendered. By signing below you understand that if benefit details were provided incorrectly to Eat, Talk & Play Therapy LLC and/or exclusions to your plan were not provided correctly, you have financial responsibility to pay for services rendered.

*I understand the above policies and agree to the terms stated. I am financially responsible for all charges and agree to pay for services in full. In the case of default payment, I am responsible for full payment of the balance, interest accrued and any collection costs and legal fees incurred to collect on this account. I, the undersigned, have read, understand and accept the information and conditions specified in this agreement.*

**Parent/Guardian Signature:** \_\_\_\_\_

**WITNESS:** \_\_\_\_\_                      **DATE:** \_\_\_\_\_



## ATTENDANCE POLICY

Following your initial evaluation, you will be contacted to schedule regular ongoing sessions. This will be your regular therapy time—UNLESS otherwise contacted by *Eat, Talk & Play Therapy LLC* prior to your session.

If you need to cancel:

- Call the clinic or email at least 12 hours prior to your scheduled appointment.
- If you have more than 2 cancelations in a row, WITHOUT rescheduling or at least 1 weeks notice, your regularly scheduled session day/time slot will NO longer be available.
- If you cancel less than 12 hours in advance, you will be charged a late cancelation fee of \$40 automatically to your credit card.
- Acceptable late cancelations are: illness or family emergency.

If your session is canceled by *Eat, Talk & Play Therapy LLC*:

- You will be contacted at least 12-24 hours in advance by phone or email.
- IF POSSIBLE: You will be offered an opportunity to reschedule your session at a later date/time that is convenient for you.

NO-SHOW appointments:

- A No-Show is when you have a scheduled appointment, and you fail to show up within at least 15 minutes of your scheduled appointment time.
- Following 15 minutes you will be contacted via phone or email, and notified that you will be charged a no-show fee of \$40 automatically to your credit card.
- If you have 2 no-shows in a row, your regularly scheduled day/time slot will NO longer be available.

I have received, read, and understand the Attendance Policy that *Eat, Talk & Play Therapy LLC* has in place. I authorize *Eat, Talk, & Play Therapy LLC* to charge my credit in the event that I have a late cancelation or no-show appointment.

\_\_\_\_\_  
Parent/Guardian Signature \_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Printed Name

\_\_\_\_\_  
*Eat, Talk & Play Therapy LLC* (Christina J. DeMichele M.S. CCC-SLP) \_\_\_\_\_  
Date

**VIDEO AND PICTURE CONSENT FORM**

I hereby give my permission to Eat, Talk & Play Therapy LLC to videotape and/or to take still photographs of my child, as named below, for purposes of: teaching, promotion on website, and data taking. I understand that any videotapes, negatives and pictures are the property of Eat, Talk & Play Therapy LLC, but that I may ask for copies for my own use. I also understand that any photographs or videotapes of my child will be shown only for the purposes of teaching other parents and/or professionals how to assess children with feeding or speech/language difficulties, marketing on Eat, Talk & Play Therapy LLC's website, or for data record keeping of patient's progress on specific goals. The videos and/or pictures of my child will not be used for any other purpose.

If I choose to decline permission now or to revoke my permission at any time in the future, I may do so without any impact on my child's care at Eat, Talk & Play Therapy LLC. If I wish to revoke my permission in the future, I will submit my request in writing to Eat, Talk & Play Therapy LLC at the address listed below.

I understand that there will be no adverse affects of photographing or filming my child, and that if my child chooses not to be cooperative with filming, the process will be terminated.

\_\_\_\_\_ **YES, I AGREE**

\_\_\_\_\_ **NO PHOTOS PLEASE**

**Name of Child:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Name of Parent/Guardian:** \_\_\_\_\_

**Signature of Parent/Guardian:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_ **Witnessed By:** \_\_\_\_\_