EAT TALK PLAY THERAPY LLC

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: _____

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Insurance Information:

Will you be seeking reimbursement from insurance (circle)? Yes No

If yes, please provide your insurance providers' information:

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 #: _____

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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: _____

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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?	Yes	No
Newborn hearing screening?	pass		refer		

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): _____

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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: _____

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Speech/Language History Continued

Is communication for your child frustrating? Yes No Comments: _____
Is you 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? _____
_____

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: _____
_____

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.

EAT TALK PLAY THERAPY LLC

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

OFFICE USE ONLY

Witness: _____ Date: _____

Comments/Restrictions: _____

_____

_____

_____

_____

3013 N. 67th Place Suite 101 Scottsdale, AZ 85251 Phone: 480.247.9190 Fax: 480.247.9718
eattalkandplaytherapy@gmail.com www.eattalkandplaytherapy.com

EAT TALK PLAY THERAPY LLC

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**
INTIALS: _____ 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:_____

3013 N. 67th Place Suite 101 Scottsdale, AZ 85251 Phone: 480.247.9190 Fax: 480.247.9718
eattalkandplaytherapy@gmail.com www.eattalkandplaytherapy.com

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 POSSBILE: 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

EAT TALK PLAY THERAPY LLC

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:** _____