## ****AUTHORIZATION AND CONSENT FOR TREATMENT, PAYMENT, AND OPERATIONS****

**Please read the following statements and sign below for acknowledgement.**

### These statements only apply to clients utilizing insurance benefits:

* I understand a prescription from my child’s physician is often needed to authorize the initial evaluation and therapy services if I am utilizing insurance benefits. It is my responsibility to obtain this when required by my insurance company.
* I have checked with my insurance company prior to this therapy visit and assert that I have obtained the necessary information regarding limits of coverage, co-pays, deductibles, and co-insurance.
* I agree to pay Fluens Children’s Therapy my cost share (coinsurance, copayment, % not paid by insurance, deductible) as agreed and stated in my insurance plan.
* I understand it is my responsibility to keep track of therapy visits used as well as the expiration date of the authorization and prescription. When this date and/or limit approaches, please communicate with my therapist to initiate the re-authorization process.
* I understand that it is my responsibility to notify Fluens Children’s Therapy of insurance changes in order to prevent lapses in services or denial of payment.
* I understand that I will be financially responsible for any therapy services rendered that are denied by my insurance company. Claims that are unpaid for more than 90 days will become my financial responsibility, and any session unpaid for more than 120 days will go to a collections agency.
* I understand that state representatives for the purpose of insurance certification or licensing and quality assurance may review my child’s records. I understand that all practices of confidentiality will be followed in use of the information gathered.
* I, the undersigned, directly assign to Fluens Children’s Therapy all medical benefits through my insurance provider. I give Fluens Children’s Therapy permission to submit bills directly to the insurance carrier. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Fluens Children’s Therapy to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all of my submissions.

### The following statements apply to all clients and all funding sources:

I consent to the treatment necessary for my child, including speech therapy, feeding therapy, PROMPT therapy, and/or any other related services that the provider or physician advise to be necessary.

I hereby give Fluens Children’s Therapy permission to evaluate and treat my child, and I understand there will be written, oral, and electronic communication between care providers/physicians, insurance companies (if using these benefits), and Fluens Children’s Therapy staff.

**I understand that payment is due at time of services rendered. If I choose to keep a card on file, Fluens will, as a courtesy to me, run my card once a week for the previously incurred charges.**

I agree and accept the above terms and service agreements. I agree that the electronic signatures, whether digital or encrypted, included in this Agreement are intended to authenticate this writing and to have the same force and effect as manual signatures.

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Parent/Legal Guardian Date

## ****ACKNOWLEDGEMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES****

Your child's privacy is important to us and, as required by law, we will protect the privacy of health information that you share. Our Notice of Privacy Practices will be posted at the location where we provide services and a copy will be available for you to download after submitting these forms. By signing below, you acknowledge that you are the parent/legal guardian of the client and have received a copy of Fluens Children’s Therapy’s Notice of Privacy Practices.

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## Parent/Legal Guardian Date

In the event medical attention is required for your child while on the premises of Fluens Children’s Therapy, we need your authorization to implement treatment. As the legal guardian of the client, do you give permission for Fluens Children’s Therapy to contact emergency personnel in the event of a medical emergency?



We will frequently call you to discuss matters related to your child’s therapy program. If we are unable to reach you on the phone number(s) provided, do you give consent for us to leave a detailed voicemail message?

Primary Contact Person:

Phone Number for Primary Contact

Relationship of Primary Contact to the Client

Alternate Contact Name

Phone Number for Alternate Contact

Relationship of Alternate Contact to the Client

Would you like to be updated via email regarding upcoming events and topics related to speech, language, and social skills?

How did you hear about us?

**General Developmental History**

In order for us to better understand your child's needs and skills, please answer the following questions to the best of your ability. These answers will help us when designing a therapy program to suit your child. If you would rather discuss any question in person, feel free to write that as your response. Thank you in advance for your assistance!

Please describe the concerns regarding your child that brought you here today.



What school/daycare does your child attend?

What does your child like best about school?

What appears most difficult for your child at school?

Who is your child's pediatrician?

What is the phone number for your child's pediatrician?

What languages are spoken in the home? Which of those languages does your child understand and use to communicate?

Who are the other people that live in your household, including ages?

Does your child have a history of seizures, serious illness, surgeries, or hospitalizations? If so, what were they and when did they occur?

Does your child have a medical diagnosis (e.g. Autism, ADHD, diabetes, etc.)? If so, what is it and when was the diagnosis received?

Has your child ever had any surgeries? If yes, please describe.

Is your child on any medications? If so, please list type, dosage, reason, and date started.

Please list the types of other services your child has received and when the services were received. Examples include other speech therapy providers, early intervention (Birth-Three), occupational therapy, counseling, etc.

Are you aware of any mental illness, developmental disorders, speech, language, or hearing problems in your family? If yes, please describe.

Please describe the conditions of your pregnancy and your child’s birth: (full term, vaginal delivery, pre-eclampsia, maternal stress, baby’s weight, etc.)

Were there any delays in achieving developmental milestones, including sitting, standing, walking, first words? If so, please describe.

Does your child have a history of recurrent ear infections? If so, how were they treated?

Please list the date and results of the last hearing test your child had completed.

Describe your child’s play (preferred toys, activities, people involved and time spent per day in these activities, solitary/with others).

Please describe things that make your child upset and what helps calm him/her.

Does your child exhibit aggressive or destructive behaviors (directed at self or others)? If so, please describe.

Is your child often frustrated, anxious or overwhelmed? How can you tell?

Does your child have challenges in reading social situations? If so, please give examples. (If your child is not yet verbal, please write N/A)

Please describe how your child interacts with his/her peers.

How well does your child understand you? Others?

Does your child follow: simple commands (e.g. put that away)? 2-step directions (e.g. get your shoes and brush your hair)? 3-step directions (e.g. pick up your toys, brush your teeth and get in bed)?

Did your child babble during infancy?

Does your child use short phrases or sentences to communicate? If so, please give some examples.

Does your child answer various types of wh- questions (who, what, where, when, why)? Does your child answer yes/no questions? Are there any that are a challenge?

How well can your child be understood by family members/familiar adults? Unfamiliar people?

Does your child make errors on specific speech sounds? If so, please describe.

How does your child compensate when not understood? (e.g., pull you to object, point to/show object, gesture, rephrase statements)

Does your child imitate speech sounds? Words? Sentences?

Does your child have difficulty maintaining conversations? If so, please describe. (If your child is not yet verbal, please write N/A)