SMART TALK SPEECH THERAPY

Tasha Chemplavil, LLC • Tasha Chemplavil, M.S., CCC-SLP
www.smarttalkspeech.com • tashac.slp@gmail.com
T: 702-339-5475 • F: 877-741-9750

PATIENT INTAKE FORM

Patient Name: _____ DOB (MM/DD/YY): _____

Parent Name(s): _____

Address: _____ City: _____ State: _____

Zip Code: _____ Home Number: _____ Cell Number: _____

Email Address: _____

Child's Primary Language _____ Other Languages: _____

Insurance Carrier: _____ Policy Number: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Phone Number: _____ Group Number: _____

Siblings and Other People Living in Home:

Name:	Age:	Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pediatrician Name: _____

Pediatrics Practice Name: _____

Pediatrician Phone Number: _____

Briefly describe your concerns about your child's speech, language, and/or learning:

_____

_____

_____

Does your child have a medical diagnosis? ☐ Yes ☐ No

If yes, please explain: _____

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DEVELOPMENTAL HISTORY

Pregnancy:

Length of pregnancy: _____ Health of Mother during pregnancy: _____

Any difficulties during pregnancy? ☐ Yes ☐ No

Check if any of the following apply:

☐ Injuries or disease of mother during pregnancy ☐ Toxemia

☐ Bleeding ☐ Maternal seizure disorder

☐ Mother needed medication ☐ Maternal alcohol and/or drug abuse

☐ Previous miscarriages ☐ Other: _____

Please further explain any complications during pregnancy: _____

_____

Delivery:

Type of delivery: ☐ Vaginal ☐ Caesarean Baby's birth weight: _____

Any difficulties during delivery? ☐ Yes ☐ No

Check if any of the following apply:

☐ Precipitous birth (labor less than 2 hours) ☐ Baby needed oxygen

☐ Prolonged labor (labor longer than 12 hours) ☐ Baby had respiratory distress

☐ Breech birth ☐ Jaundice

☐ Baby had cord around neck ☐ Rh incompatibility

☐ Prematurity ☐ Other: _____

Please further explain any complications during delivery: _____

_____

Adoption Information (complete only if appropriate):

Child's age when adopted: _____ Is child aware of adoption? ☐ Yes ☐ No

Other relevant information: _____

_____

Developmental Milestones:

At which age did your child:

Roll over? _____ Sit? _____ Crawl? _____ Walk? _____ Talk? _____

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MEDICAL HISTORY

Check and explain is any of the following apply:

- ☐ Allergies: _____
- ☐ Cerebral Palsy
- ☐ Cleft Lip Palate (please specify) _____
- ☐ Ear infections: Frequency _____
- ☐ P.E. tubes (which ear?) _____
- ☐ Encephalitis
- ☐ Failure to thrive
- ☐ Meningitis
- ☐ Eye disorder (specify) _____
- ☐ Wears glasses
- ☐ Seizure disorder
- ☐ Head injury
- ☐ Special diet
- ☐ Autism Spectrum Disorder
- ☐ Down Syndrome
- ☐ Other: _____

Has your child had surgery or been hospitalized?

Date:	Age:	Procedure:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is your child presently taking any medication? Please specify medicines and conditions:

_____

_____

Hearing Status:

Have you ever questioned your child's hearing? ☐ Yes ☐ No

If yes, please explain: _____

Has your child had a formal hearing test? ☐ Yes ☐ No

If yes, when and what were the results? _____

Feeding:

Did your child have difficulty chewing, swallowing, or drinking? ☐ Yes ☐ No

If yes, please explain: _____

Does your child currently have difficulty eating? ☐ Yes ☐ No

If yes, please explain: _____

Play Skills:

Does your child prefer to play alone or with others? _____

What types of toys does your child play with? _____

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Family History:

Is there a family history of speech and/or language problems? ☐ Yes ☐ No

If yes, please explain: _____

Behavior Information:

Please check if your child has problems with any of the following:

☐ Attention	☐ Immaturity	☐ Poor motivation/apathy
☐ Aggression	☐ Impulsivity	☐ Shyness
☐ Anxiety	☐ Low self-esteem	☐ Short attention span
☐ Bedwetting/toileting	☐ Manipulative	☐ Sleep problems
☐ Depression	☐ Moodiness	☐ Substance abuse
☐ Disruptive behavior	☐ Nail biting	☐ Temper tantrums
☐ Difficult to manage	☐ Nightmares	☐ Tics/nervous gestures
☐ Frequent crying	☐ Noncompliance	☐ Truancy
☐ Hyperactivity	☐ Not interested in peers	☐ Other: _____
☐ Getting along with peers	☐ Perfectionism	

Please list any other professionals your child has seen for speech, language, and/or developmental concerns:

_____

_____

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EDUCATIONAL HISTORY

Did/does your child attend school? ☐ Yes ☐ No
If yes, where? _____

Is this a private or public school? ☐ Private ☐ Public

What grade is your child in? _____

Has your child ever repeated a grade? ☐ Yes ☐ No

If yes, please explain: _____

Does your child have an Individualized Education Program (IEP)? ☐ Yes ☐ No

Does your child: ☐ Label letters ☐ Read ☐ Write

Does your child enjoy reading/having books read to him/her? ☐ Yes ☐ No

Does your child enjoy school? ☐ Yes ☐ No

Has or is your child receiving:

	Current	Past	Age/Grade	Frequency	Location
Special Education Classes					
Remedial Classes					
Tutoring					
Speech/Language Therapy					
Physical/Occupational Therapy					
Counseling/Therapy					

Please provide any relevant details for above checked boxes: _____

_____

_____

How is your child currently doing in school? _____

_____

_____

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SERVICE CONTRACT

Tasha Chemplavil, M.S., CCC-SLP is a Speech-Language Pathologist, registered in good standing with the American Speech and Hearing Association (ASHA).

FEES

Services are billed through Fee-For-Service Medicaid, and billable services include, but are not limited to: assessment, treatment, caregiver training, team meetings, phone/email consultations.

Parents/guardians agree to provide necessary information for use in billing Medicaid for services.

Name of Beneficiary _____ Medicaid ID _____

I request payment of authorized Medicaid benefits to me or on my behalf for any services furnished me by Tasha Chemplavil LLC. I authorize any holder of medical information about me to release to Medicaid and its agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature Date

APPOINTMENTS

Appointments will be 30-60 minutes in length, including 5 minutes reserved for session note taking, preparation of home practice materials, and receipt of service fees.

Parents and/or caregivers are required to be present for all therapy sessions and be active participants in the therapy process. They will be encouraged to integrate home practice into their daily routines and maintain open lines of communication with the service provider to support the client's communication development.

CANCELLATIONS

24 hours notice is requested for all cancellations. Rescheduling of missed appointments will always be an option. If more than 3 appointments are missed in a row, a discussion regarding the termination of services will be initiated by the clinician.

COMMUNICABLE DISEASE POLICY

It shall be the policy of Tasha Chemplavil, LLC dba Smart Talk Speech Therapy to abide by the following:

All patients, or parents or guardians of patients, shall telephone to cancel and reschedule appointments when the patient may have one or more symptoms of a contagious disease. This will aid in the protection of the health of the staff, other patients, and family members.

Symptoms:	Fever >100 degrees F	Chicken Pox	Conjunctivitis/Pink Eye
	Vomiting/Nausea	Measles	Strep Throat
	Open/Draining Lesion	Productive Cough	Diarrhea
	Lice	Impetigo	Other contagious diseases

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Protection of Health Information: Your health information is kept private according to the federal privacy regulations under the Health Insurance Portability and Accountability Act of 1966 (HIPAA) and you are provided with notices of the legal duties and privacy practices within this practice. Your protected health information is information that relates to your past, present, or future health care. This includes your medication history, diagnostic evaluations, and therapeutic services.

Uses and Disclosures of your protected Health Information: Disclosure of your health information may occur for health care operations. Examples of operations in which protected health information disclosures may occur include insurance and billing, management, financial or quality assurance audits, law enforcement purposes, education, referring to other services, and receiving information from other professionals that may have treated you in the past. Your protected health information may be used for treatment purposes inducing provisions, coordination or management of services. Some other examples of disclosures include the following:

- Messages may be left on your answering machine regarding your appointment or to request that you contact this office
- Medical records may need to be transferred to another location
- Disclosures may also be made to student observers or therapists who participate in health care operations and commit to respect the privacy of your health information

Your Rights Regarding Your Health Information: You have the right to review your health information, which might include intake information, evaluation, session notes, goals, and progress notes. For all other purposes beyond those listed above, your written authorization will be required to use, disclose, or restrict your protected health information. Your authorization can be revoked at any time except to the extent that we have relied on the authorization. Revocations must be in writing. You may also initiate the process for your information to be sent to someone else through the use of an authorization form or written request. To request further restriction or disclosure, you must submit a written request that explains what information you want restricted, how you want the information restricted, and from whom you wan the restriction to apply.

Notice of Privacy Practices: By law, this practice abides by the terms of this Notice of Privacy practices until we choose to change it. We reserve the right to change this notice at any time. The revised notice will be available on request from our office.

Complaints: If you believe that your privacy rights have been violated, you may submit a complaint to the practice or to the U.S. Department of health and Human Services. To file a complaint with the practice, submit the complaint in writing. You will not be penalized or retaliated against for filing a complaint and your identity will be kept confidential.

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CLIENT EMAIL/TEXTING INFORMED CONSENT FORM

1. Risk of using email/texting

The transmission of client information by email and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

a. Email/texts can be circulated, forwarded, stored electronically on paper, and broadcast to unintended recipients.

b. Email/text senders can easily misaddress an email or text and send the information to an undesired recipient.

c. Backup copies of emails/texts may exist even after the sender and/or the recipient has deleted his or her copy.

e. Emails/texts can be intercepted, altered, forwarded or used without authorization or detection.

f. Email/texts can be used as evidence in court.

g. Emails/texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. Conditions for the use of email and texts

Therapist cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Therapist is not liable for improper disclosure of confidential information that is not caused by Therapist's intentional misconduct. Clients/Parent's/Legal Guardians must acknowledge and consent to the following conditions:

a. Email/texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.

b. Email/texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.

c. All email will usually be printed and filed into the client's medical record. Texts may be printed and filed as well.

d. Provider will not forward client's/parent's/legal guardian's identifiable emails and/or texts without the client's/parent's/legal guardian's written consent, except as authorized by law.

e. Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information.

f. Provider is not liable for breaches of confidentiality caused by the client or any third party.

g. It is the client's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.

3. Client Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between my therapist and me, and consent to the conditions and instructions outlined, as well as any other instructions that my Therapist may impose to communicate with me by email or text.

_____ _____

Signature Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PRACTICE POLICIES

I acknowledge that I received a copy of the Notice of Privacy Practices and Practice Policies from Tasha Chemplavil, LLC.

_____ _____

Signature Date

ACKNOWLEDGEMENT OF CLIENT EMAIL/TEXTING INFORMED CONSENT FORM

I acknowledge that I received the Client Email/Texting Informed Consent Form. I acknowledge that I have read and fully understand the Client Email/Texting Informed Consent Form. I understand the risks associated with the communication of email and/or texts between my therapist and me, and consent to the conditions and instructions outlined, as well as any other instructions that my Therapist may impose to communicate with me by email or text.

_____ _____

Signature Date

My signature below indicates my acceptance of the terms outlined above in the Service Contract. I understand that services may not proceed without my consent.

_____ _____

Signature Date

Tasha C—l, M.S. CCC-SLP _____

Tasha Chemplavil, M.S., CCC-SLP Date
Certified Speech-Language Pathologist

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CONSENT FOR AUDIO/VIDEOTAPING

At times, audio and videotaping may be deemed to be of clinical benefit during the assessment and treatment process. The materials will remain protected and the property of Tasha Chemplavil, LLC and only shared with express consent from the client or caregiver. Tasha Chemplavil, LLC also has a web site that is used for promotion and education. Below is the option to permit or decline for Tasha Chemplavil, LLC to use these photos/videos for educational purposes and legal promotion of the clinic.

❖ **Check ONLY ONE Box Below and Fill out ONLY ONE Section Below.** ❖

Permission to Use Images

I grant to Tasha Chemplavil, LLC, its representatives, and employees, the right to take photographs/video of my child. I agree that Tasha Chemplavil, LLC may use such photographs of my child with or without my name and for any lawful purpose, including, for example, such purposes as education, publicity, illustration, advertising, and web content.

☐ I have read and understand the above and give permission for the above use:

Signature of Legal Guardian_____ Child's Name _____

Printed Name _____ Date _____

☐ Check here if you **DO NOT** want your child's picture or video taken and used for publicity, but grant permission to use photos or videos for **treatment or assessment purposes**.

Signature of Legal Guardian_____ Child's Name _____

Printed Name _____ Date _____

☐ Check here if you **DO NOT** want your child's picture or video used for any purpose.

Signature of Legal Guardian_____ Child's Name _____

Printed Name _____ Date _____