The
LANGUAGE
LEARNING CENTER
Empowering the Mind to Work its Best

69 "A" Lindsey Lane St. Marys, GA 31558
(912) 729-2294~Fax (912) 673-9457

Patient Information

(PLEASE PRINT LEGIBLY)

Patient's Last Name: __________________________First Name____________________ MI: ____
Patient's Address :___________________________________City: _________________________
State:______ Zip Code:_____________ Birth Date: ____________________ Age: _____________
Male Female Patient's Social Security Number:_______________________________________
School:____ Grade:_______________________
Primary Physician: ____________________________ Date of Last Exam: ___________________
Referring Physician (if not primary) ____
Medications Patient is currently taking:____
____
Any medical or environmental allergies? _______ if yes please list __________________________
____
Any Medical Diagnosis?: _______ if yes please list ____
____

Parent/Guardian Information

Last Name: _________________________ First Name: _______________________ MI: ________
Relationship to patient ____
Address : ____________________________________City:______________________ State:_____
Birth Date: ___________________ Social Security Number: _______________________________
Employer:____
Home Phone: _______________ Work Phone: ________________ Cell Phone: ________________

Last Name: ________________________ First Name: ________________________ MI: ________
Relationship to patient ____
Address : ____________________________________City:______________________ State:_____
Birth Date: ___________________ Social Security Number: _______________________________
Employer:____
Home Phone: _______________ Work Phone: _______________ Cell Phone: _________________

Nearest relative not living with you: ___________________________ Phone: _________________
Nearest friend not living with you: ____________________________ Phone: _________________

Whom may we contact in the case of an emergency? (Provide Two)

Name: ___________________________Relationship: _______________ Phone: _______________
Name: ___________________________Relationship: _______________ Phone: _______________

What is the reason for today's visit? ____
____
____
____

Patient History

A). Prenatal & Birth History

1. Were there any complications with pregnancy or birth? _______ If yes, please describe____________
____
____

2. During this pregnancy did the mother smoke __________, consume alcohol or drugs? ____________
If yes to either, how much & how often? ____

3. Length of pregnancy___________________. Child's Birth Weight _____________________________

B). Developmental History

1. Did your child reach physical milestones (sitting, crawling, walking) at appropriate ages? _______ If no please describe any delay(s) ____
____
____

2. Do you have any concerns regarding your child's development?________ If yes, please describe____
____
____

C). Speech History

1. At what age did he/she:
Say first words? _____________ Did he/she keep adding words once they started? ________________
Begin to name people and objects? ____
Have a name for almost everything? ____
Use word combinations like "want cookie" or "more juice"? ____________________________________
Use more complete sentences? ____

2. Did speech learning ever seem to stop for a period of time? ________If so, describe: ____________
____

D). Health History

1. Please list any illnesses that the child has experienced, for example; measles, chicken pox, ear infections, tonsillitis, etc. ____
____

2. Has the child ever run a high fever for a prolonged period of time? _________ If yes, please describe____
3. Please list any surgeries (age and reason) ____
____

4. Please describe any hospitalizations (age and reason)______________________________________
____

5. Please describe any emergency room visits (age and reason)__________________________________
____

6. Any relevant family health history? ______ if yes please describe ___________________________
____

E). Feeding/Food Sensitivities

1). Would you describe your child as a "picky eater" or does he/she have any aversions to certain food textures? ________ if yes, please describe ____

____

____

2). Does your child have any feeding peculiarities (packing mouth overfull, drink extraordinary amounts of beverage with a meal, inappropriate/uncoordinated tongue movements, etc)?________ If yes, please describe ____

____

3). Does your child appear to have any difficulty with eating (trouble swallowing, choking, gagging or vomiting at mealtime)? _____________ If yes please explain __________________________________

____

____

F). Hearing Status

1. Does your child: (circle *yes* or *no*)

- Hear if his/her back is turned *yes no*
- Talk in a very loud voice? *yes no*
- Turn up the volume on the radio and/or T.V.? *yes no*
- Hear if you talk to him/her from another room? *yes no*
- Have a history of ear infections? *Yes no*

2. Does your child seem to have difficulty hearing? ____________, If so please describe: ___________

____

3. Has your child had a hearing test? _________ If yes when, where, by whom and results? __________

____

G). School History

1. At what age did the child start school? _________ Were any grades repeated? ________If yes why?

____

2. Are there any subjects with which he/she has particular difficulty? __________ If yes please describe

____

3. Have you communicated or met with your child's teacher to discuss any problems or school issues? ______ If yes, please describe ____

____

4. How does he/she get along with others in school? ____

5. What grades did your child receive on his/her last report card? ______________________ are those grades typical for your child? ____

6. Is your child served by an IEP (individualized education plan)? ________________________________

7. Does your child have a behavior modification plan at school? ______________________________

H). Other Examinations

(We may request reports from these examiners/teachers upon your release to do so.)

1. Has the child ever had a speech evaluation prior to this time? _________________If so, when, where and by whom? ____

2. Has he/she ever received speech therapy?____________ If so, when, where and by whom? ________

____

3. Has he/she had a psychological examination? _________________ If so, when, where and by whom?

____

<u>If you have concerns regarding your child's articulation and/or ability to be understood</u>

please complete the following questions:

Child's name: ___________________________________ Child's age __________

Male or Female (circle one) Language spoken in your home _________________________

Person completing the form: ____

Relationship to child: ____

The following questions are about how much of your child's speech is understood by different people. Please think about your child's speech in conversations over the past month when answering each question. Check one box for each question.

	Always (5)	**Usually (4)**	**Sometimes (3)**	**Rarely (2)**	**Never (1)**
1. Do you understand your child					
2. Do immediate members of your family understand your child?					
3. Do extended members of your family understand your child?					
4. Do your child's friends understand your child?					
5. Do other acquaintances understand your child?					
6. Do your child's teachers/babysitters/daycare staff understand your child?					
7. Do strangers understand your child?					
Shaded areas are for Therapist use only					
				Total Score	

8. What does your child do when they are not understood? _______________________________________
____
____

9. Does your child stutter or stammer when speaking? ________ If yes please describe _____________
____
____

10. Please review the letter/sound list below and indicate any that your child has difficulty with. You may also circle the words indicating the sound is said incorrectly in the beginning, middle or end of the word.

	Sound
	/p/ as in pig, apple, cup
	/b/ as in bat, baby, web
	/t/ as in toy, water, tent
	/d/ as in doll, middle, bed
	/k/ as in king, pocket, rake
	/g/ as in goat, buggy, tag
	/m/ as in mad, hammer, thumb
	/n/ as in name, funny, fan
	/ng/ as in finger, ring
	/r/ as in run, carrot, fur
	/er/ as in early, nurse,
	/l/ as in lion, pillow, tall
	/h/ as in hat, anyhow

	Sound
	/f/ as in food, coffee, off
	/v/ as in vote, oven, stove
	/s/ as in sock, missing, ice
	/z/ as in zoo, fuzzy, fuzz
	/sh/ as in shoe, wishing, fish
	/zh/ as in pleasure
	/ch/ as in chair, watching, pitch
	/j/ as in judge, engine
	/th/ (soft) as in thing, healthy, tooth
	/th/ (hard) as in those, brother, bathe
	/w/ as in way, anyway
	/y/ as in yellow, canyon

Permission to Evaluate and Treat

I, ______________________________hereby give permission to **The Language Learning Center** to evaluate and treat me\my child according to my\my child's physician's order (where applicable), and obtain information pertinent to that evaluation and treatment from other professionals familiar with my\child's circumstances when such information is judged to be necessary to complete the evaluation process.

In addition, I give permission for **The Language Learning Center** to exchange information with other professionals, and request medical records from my\my child's physician(s) or other agencies involved in my\my child's treatment, when this is considered to be in my\my child's best interest.

I understand that any information shared with or by The Language Learning Center will be treated as privileged and confidential.

Signature: ________________________________ Date: _________________________

As a courtesy to you The Language Learning Center accepts and files your insurance claim(s). However it is important for you to understand and agree that (regardless of your insurance status) you are ultimately responsible for any co-payments, co-insurance, deductibles and or any balance you\your child may incur for any professional services rendered by the Language Learning Center. It is also your responsibility to notify the appropriate staff member(s) of the Language Learning Center of any changes in your status or the above information.

__________________________________ __________________________

Signature Date

__________________________________ __________________________

Parent (if minor) Date

Please fill out the following insurance information if you are planning to use insurance. **Also provide our staff with a copy of both the front and back of your insurance card**.

Primary Insurance

Insurance Company: ____
Member ID _________________________________ Group # _________________________
Sponsor's Last Name: ________________________ First: _____________________MI_____
Sponsor's Date of Birth: ___________________Sponsor's ID: _________________________
Sponsor's Social Security: ____________________ Employer _________________________

Secondary Insurance

Insurance Company: ____
Member ID _________________________________ Group # _________________________
Sponsor's Last Name: ________________________ First: _____________________MI_____
Sponsor's Date of Birth: ___________________Sponsor's ID: _________________________
Sponsor's Social Security: ____________________ Employer _________________________

ASSIGNMENT OF INSURANCE BENEFITS

The Language Learning Center
69 A Lindsey Lane
St. Marys, GA 31558 Date_____________

Patient Name: ____
Sponsor Name: ____
Employer: ____
Sponsor ID #: ______________________ Sponsor SS #: _________________________

Release of Information / Assignment of Benefits
I hereby authorize The Language Learning Center Inc., to furnish information to my insurance carriers concerning any treatment and hereby assign to The Language Learning Center Inc., all payments for service rendered to me and/or my children (if covered under my insurance policy). I understand that I am responsible for my and /or my children's account and any amount not covered by my health insurance. I further agree in the event of non-payment, to bear the cost of collection, court fees, and legal fees should this be required.

THIS IS A DIRECT ASSIGMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.
This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case

I authorize The Language Learning Center to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at: _____________________this: _________day of _______________, 20______.

______________________________ ______________________________
Signature of Policyholder Witness

___________________________ Relationship to Policyholder: ____________________
Signature of Claimant\Guardian, if other than Policyholder.

Scheduling Policy

A great deal of preparation and effort is made by The Language Learning Center therapists and staff to give your child the best care possible. Keeping ALL appointments and being prompt is imperative to ensure the patient receives the maximum benefits for their particular program. Unfortunately, once an appointment is missed it becomes easier to miss the next. This does not aid the patient's progress. Due to an unusual number of No-Shows and last minute Cancellations we find in necessary to implement a Schedule Policy:

We ask all our families allow a minimum of * 12 hours prior to the appointment for cancellation. This allows our staff to schedule another child for therapy. Failure to meet the 12 hour minimum prior notice will result in you being billed $15.00. This cost will be billed directly to you as the Parent/Guardian and is an expense NOT covered by any insurance coverage. If you are unable to give 12 hours notice *due to an emergency*, no fee will be assessed.

Further, after 3 consecutive No-Shows or 5 No-Shows within a 1 year period, The Language Learning Center will have no choice but to dismiss your child and fill that appointment time with a child from our waiting list.

Thank you for your attention to this notice.

______________________________ Parent/Guardian signature

________________ Date

* Our answering machine is available after hours and will accept messages regarding cancellations.

Letter of Attestation

Date_______________

Child's Full Name ____

Date of Birth ____

Parent/Guardian Full Name ____

Insurance Company ____

(Ins) Member ID Number ____

School Attended ____

To Whomever it may concern,

Please consider this letter as a statement of attestation that my child ___________________ does /does not receive speech therapy services in the public school which he/she attends.

Check one

- [ ] My Child does not have an IEP.
- [ ] My Child has an IEP that does not include speech therapy services.
- [ ] My Child has an IEP that includes speech therapy services.

Signed ____ Date ____________________________

Relationship to child _____________________________