



**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: \_\_\_\_\_

\_\_\_\_\_

Whom may we contact in the case of an emergency?

(Please provide two not living in your household)

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, drinking extraordinary amounts of beverage with a meal, inappropriate/uncoordinated tongue movements, problems chewing certain foods, etc)?\_\_\_\_\_ If yes, please describe \_\_\_\_\_

3). Does your child appear to have any difficulty with eating (trouble swallowing, problems chewing, 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? \_\_\_\_\_

**If you have concerns regarding your child's articulation and/or ability to be understood  
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.*

	<b>Always (5)</b>	<b>Usually (4)</b>	<b>Sometimes (3)</b>	<b>Rarely (2)</b>	<b>Never (1)</b>
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?					
<b>Shaded areas are for Therapist use only</b>					
<b>Total Score</b>					

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.

	<b>Sound</b>
	/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

	<b>Sound</b>
	/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 it 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 \_\_\_\_\_

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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.

My Child does not have an IEP.

Check  
one  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 \_\_\_\_\_