Dear Family,

Welcome to The Speech Dynamic Speech, Language, and Myofunctional Therapy!

Thank you for choosing The Speech Dynamic, PLLC to help your child achieve his speech and language goals. We realize that you have options regarding speech therapy for your child and we are happy you selected us to assist your child in achieving these goals. The new client paperwork packet includes important information about the therapeutic process including financial, attendance and privacy policies. Please take time to fill out the client history form as completely as possible to enable a most accurate treatment plan. Additionally, if your child has had any recent assessments completed by other health care professional including but not limited to an Audiologist, ENT, etc. please provide copies so that we are able to get the whole picture of your child. Completed form packets may be brought to the initial visit or emailed to BrookeAndrews@thespeechdynamic.com

Sincerely,

Brooke Andrews, M.A., CCC-SLP
Licensed Speech-Language Pathologist
TX license # 111520
ASHA certification # 12153533

The Speech Dynamic- Pricing

Assessment: We utilize both informal and formal testing measures, including child/parent/caregiver interview, clinical observations, play-based assessment when necessary, as well as standardized tests to evaluate your speech and language skills. We look at your child's strengths and needs in different areas of communication. A written evaluation, recommendations, and strategies for your child's specific communication profile is provided.
60-90 minutes
Price:
Language Assessment: $ 350

Therapy: We use evidence based treatment approaches and customize a plan based on you child's strengths and needs. All therapy is individualized to meet your child's unique learning style, incorporate his/her personal interests, and capitalize on his/her strengths to support growth and development of his/her language skills. A summary of the session is provided for the parents and a home plan with written strategies to work on during the week..

$135: 45 minutes
Travel time: $15 per 15 minutes

Payment: We are currently an out-of-network provider with all insurance companies. However, this does *not* mean that your insurance company will not cover some/all services.

Payment for services is provided directly by the family to The Speech Dynamic via check or our secure online portal. Once payment is received, families are provided a Paid Invoice with treatment/evaluation service and diagnosis codes. Please call your insurance company to find out if you are eligible for out-of-network speech language therapy and/or evaluation reimbursement. Ask if your insurance company accepts CPT code 92507 and if they require an ICD-10 code (furnished from an evaluation). Should insurance companies require additional documentation to authorize, justify, and/or extend services, we are happy to provide the necessary paperwork.

If pursuing an evaluation only, ask if your company accepts code 92523

Informed Consent for Speech Therapy

I, _____, the parent/legal guardian of

_____ hereby request and consent for The Speech Dynamic, PLLC to perform treatment and care for my child

I acknowledge and agree that the parent/caregiver plays an integral role in a treatment and agree that a parent or caregiver will be present during each treatment session.

I have carefully read and fully understand this Informed Consent Form and have had the opportunity to discuss it with the treating therapist.

I consent and authorize The Speech Dynamic PLLC to administer treatment under the direction and supervision of a licensed Speech-Language Pathologist.

_____ _____

Parent/Legal Guardian's Signature Date

Policies and Procedures

Payment: We are currently an out-of-network provider with all insurance companies. However, this does not mean that your insurance company will not cover some/all services. Payment for services is provided directly by the family to **The Speech Dynamic via check or cash at the time of service**. Once payment is received, families are provided a Paid Invoice with treatment/evaluation service and diagnosis codes. Please call your insurance company to find out if you are eligible for out of network speech language therapy and/or evaluation reimbursement. Ask if your insurance company accepts CPT code 92507 and if they require an ICD-10 code (furnished from an evaluation). Should insurance companies require additional documentation to authorize, justify, and/or extend services, I am happy to provide the necessary paperwork.

Cancellation, Make-Ups and No Shows: In the event that your child is not able to make an appointment, please contact Brooke via e-mail BrookeAndrews@thespeechdynamic.com or via phone 713-659-9346 Continuity of therapy is vital for the success of your child. We encourage make-ups for consistency of care. If you know you will be away, we will work together to schedule you either before or after you return. We use the following guidelines for your appointments.

In order to avoid a charge, please call or e-mail at least 24 hours in advance for any cancellation and/or to reschedule. Unfortunately, we will need to bill cancellations with less than 24 hours at the full session rate.

Vacations: **We do not "hold" spots for vacations over two weeks.** If you are away for longer than two weeks, please contact your therapist when you are back in town to see if you can schedule a new appointment.

However, if you are able to make-up the appointment at some other point within 1 week, then you will not be charged for the session.

*NOTE: We understand that life happens, and that sometimes your child will not be able to make an appointment. Therefore, we allow 1 “free pass” without a fee.

Sessions: Sessions typically run 60 minutes. The last five-ten minutes of each session will be spent reviewing the session with a parent or caregiver and discussing strategies to work on at home. Articulation sessions are typically 30-45 minutes.

Confidentiality: Your privacy is very important to us. I recommend that you review the Notice of Privacy Policy for important details for maintaining confidentiality.

Termination of Services: Clients may terminate therapy services by phone, email, written notice or in person, at any time, for any reason. In the event that you do not honor your financial obligations to the Speech Dynamic, PLLC, services will be terminated. If a client accumulates three no-shows, termination of therapy is warranted. The Speech Dynamic, PLLC reserves the right to terminate services if I determine that the therapy schedule is not aggressive enough to guarantee positive outcomes in a reasonable amount of time

Comments, Questions, Complaints: All feedback is encouraged! The Speech Dynamic, PLLC strives to be the best in speech/language therapy. Positive comments are always welcome, and information about things I can do better is very valuable. If there is something you are not happy with, please bring it to our attention. Every effort will be made to make the necessary changes to make your experience positive.

Changes in Policy: The Speech Dynamic, PLLLC reserves the right to make policy changes at any time. Clients will be informed of any policy changes prior to their implementation.

You will only be contacted via the method(s) chosen on your Contact Information form. It is up to you to make sure contact information is kept current. If you would like The Speech Dynamic to exchange information with another person or professional, an Authorization for Release of Information form must be completed.

I acknowledge and agree to the following policies and procedures

_____ _____

Signature Date

Credit Card Payment Authorization

You authorize regularly scheduled charges to your Credit Card. You will be charged the amount indicated below each billing period. A receipt for each payment will be provided to you and the charge will appear on your Credit Card Account Statement. You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

I _____ authorize The Speech Dynamic to charge my Credit Card on file below for $`115/45 minutes following each speech therapy.

Goods / Services Rendered: Speech Therapy

Billing Details

Billing Address _____ Phone # _____

City, State, Zip _____ Email _____

Credit Card Information

❑- Visa ❑- MasterCard ❑- AMEX ❑- Discover

Cardholder's Name - _____ Expiration Date _____

Card Number: _____ CVC Code: _____

Individual's Signature _____ Date _____

The Speech Dynamic, PLLC Brooke Andrews, M.A. CCC-SLP / 2055 Colquitt St / Houston, Texas 77098 Phone 713-659-9346 / www.thespeechdynamic.com

2-Way Release of Information

I, _____, have provided a complete and up to date list of all of my current physicians and providers of care in the list below along with their phone numbers and specialty. I am authorizing The Speech Dynamic/ Brooke Andrews and all of the physicians and other individuals or groups listed to consult and communicate freely regarding my progress, prescriptions and any issues that may affect my child's health, safety, recovery progress as deemed appropriate by Brooke Andrews and/or the physicians I have listed below. I understand that this supports my continuity of care and may increase the quality of service I receive as a whole. I may also list any family members or other service providers whom I wish to be included for continuity of care. I understand that I do not have to sign this release and if I choose not to I may speak with my physician or other providers of care.

Physician _____

Specialty _____

Phone _____

Other Provider (OT, PT, etc.) _____

Phone _____

Client's Name (printed) _____

Client's Signature _____

Date _____

Acknowledgment That You Have Received Our HIPAA Privacy Notice

The Speech Dynamic, PLLC is required by law to keep your health information safe. This information may include:

- notes from your doctor, teacher, or other health care provider
- your medical history
- your test results
- treatment notes

Protecting the privacy of your child and your family is extremely important to us, and HIPAA mandates it. Some information will be transmitted electronically. The HIPAA privacy rule allows us to communicate with you electronically provided that we apply reasonable safeguards when doing so. The privacy rule does not prohibit the use of unencrypted email and text for treatment related communications. For written progress reports, appointment reminders, updates etc, you have my permission to:

Check all that apply

Send e-mails from our HIPPA compliant server

Send text messages regarding appointment confirmations and times

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information may be used and shared. It also tells you how you can look at and comment on your information.

By signing this page, you are saying that you have been given a copy of our privacy notice.

_____ _____

Print Child's Name Date

_____ _____

Patient or Parent/Guardian Signature Relationship to Child

Case History Form

Child's Name: _____ DOB: _____

Mailing Address:

_____

_____

Parent E-mail: _____

Home Telephone: _____ Cell: _____

Child's Physician: _____ Phone:_____

*Information provided in this history is confidential and used to help in the assessment of your child. This information will not be provided to other agencies without your written consent

Family History:

Mother's Name:_____ Occupation:_____

History of Speech, Language, or Learning Problem _____ YES _____ NO

If YES, please explain _____

Father's Name:_____ Occupation:_____

History of Speech, Language, or Learning Problem: _____ YES _____ NO

If YES, please explain: _____

Child's Sibling's- Names & Ages: _____

Who currently lives at home with your child:_____

Is there a family history (parent, siblings, aunt, uncles, cousins, grandparents) of any of the following:

	Family Member		***Family Member***
Hearing Loss	_____	*Alcoholism*	_____
Learning Disability	_____	*Seizure Disorder*	_____
Reading Difficulty	_____	*Mental Illness*	_____
Speech Difficulty	_____	*Drug Abuse:*	_____

Is English the only language spoken at home _____*YES* _____ *NO*

If NO, what is the primary language spoken at home?: _____

Prenatal & Birth Complications: *Check any items that apply during the birth of your child:*

During pregnancy:

_____ Excessive Vomiting _____ RH Incompatibility _____ Significant Illness

_____ Drug use _____ Alcohol Use _____ Smoking

_____ Previous Miscarriages _____ Trauma/Injuries _____ High blood pressure

Labor & Delivery

_____ Full Term _____ Premature: _____ weeks early

_____ Normal Delivery _____ Forceps Delivery

_____ Cesarean _____ Birth Weight

Complications After Birth:

_____ Difficulty Breathing _____ Difficulty sucking _____ Difficulty Feeding

_____ Seizures _____ Jaundice

Please explain any items above: _____

_____

Medical History: Has your child had any of the following?

_____ Chicken Pox _____ Encephalitis _____ Asphyxia (Oxygen/breathing loss)

_____ Meningitis _____ Asthma _____ Allergies

_____ Head injury _____ Seizures _____ Tonsils/Adenoids Removed

_____ Multiple Ear Infections Tubes Inserted _____? Which ear?_____

Additional Information: _____

_____
_

List any medications your child currently takes, dosages, and why:
_____

_____
_

List any other diagnosis your child has been found to have:
_____

_____
_

Hearing History:

Do you suspect your child has a hearing loss? _____

If YES, what behavior does your child display that lead you to suspect a hearing loss?

_____
_

Has your child's hearing been tested? _____ YES _____ NO

Where and When:
_____

Results of Testing:
_____

Does your child have hearing aids?: _____ YES _____ NO

If so, in which ears: _____

Has your child had 4 or more ear infections within the last 6 months? _____ YES _____ NO

Speech/Language Development: Please indicate the approximate age your child reached the following milestones (estimate):

_____ Cooing, pleasure sounds _____ Babbling (ba-ba da-da)

_____ Jargon (talking in his/her "own language") _____ single words

_____ Phrases (if applicable)

How does your child let you know what he/she wants? Please check all that apply

_____ Looking at objects _____ Pointing to Objects _____ Gestures

_____ Crying _____ Making sounds _____ Touch/grab

_____ Single words _____ 2-3 words _____ Sentences

Describe your child's speech

_____ Easy to understand

_____ Easy for family members to understand, difficult for others

_____ Difficult for family members to understand and also difficult for others to understand

Does your child get "stuck" or "stutter" while speaking?
_____

Explain: _____

Does your child have difficulty with pronouncing certain kinds of words?:
_____

Explain:
_____

Do you have concerns about your child's voice? (hoarse, breathy, soft, very loud) _____

Explain: _____

Describe the speech and language problems you notice with your child: (ex: not talking, using only few words, using one word, saying words incorrectly, repeating words)

_____
_____
_____
_____
_____

Is your child aware or frustrated by his/her speech and language difficulties? If yes, Explain Y or N

_____

_____

Is your child's speech and language difficulties noticed by others? If yes, please tell who. Y or N

_____

_____

Has your child received speech therapy or another developmental therapy (OT, PT, etc.) before?

If YES, where and for how long?:_____

_____
_

Does your child (please check what applies only)

___ identify common objects (chair, table) ___ understand/follow commands (get cup, come here)

___ identify actions (run, walk, talk) ____ respond correctly to "wh" questions (who, what)

___ respond correctly to yes/no questions ____ understand basic concepts (up/down, in/out)

Does your child imitate sounds? _____

Does your child imitate words: _____

Check which gestures your child uses:

Which gestures does your child use
_____ giving

_____ pushing away
_____ raising arms
_____ showing
_____ reaching
_____ waving
_____ shaking head “no”

Motor Development: What age did your child demonstrate the following (estimate)

_____ Sitting up _____ Crawling _____ Standing

_____ Walking _____ Finger Feeding _____ Eating with a spoon

_____ Potty-trained (if applicable) _____ undressing self (if applicable)

Feeding/Eating:

Has your child any feeding difficulties?

_____ Sucking or nursing _____ Excessive length of time to drink a bottle

_____ Regurgitation of liquids through the nose _____ Difficulty chewing or swallowing

_____ Choking and/or gagging _____"Picky eater"

If you describe your child as "picky," which food do they prefer?: _____

_____

Social/Emotional Development: Check behaviors that describe your child:

_____ Overly quiet _____ Overly active _____ excessive tantrums

_____ Destructive _____ Friendly/outgoing _____ plays well with other children

_____ Prefers older kids _____ Prefers younger kids _____ Defiant

_____ Trouble sleeping _____ Plays poorly with others

_____ Prefers to play by himself _____ Plays "along side," but not "with" other children

Check all that apply:

___ uses social greetings (hi, bye) ___ makes eye contact

___ plays well with others ____ shares toys/things easily

___ initiate play with others ___ takes turns

Check all of the types of play your child likes to do the most often:

_____ Putting toys in mouth _____ Banging toys together _____ Throwing toys

_____ Pushing/pulling toys _____ Uses toys appropriately _____ Rough and tumble play

_____ Role-playing games _____ Make believe play _____ Games with rules

Describe any emotional or behavioral concerns:
_____

_____

Educational History:

School/
Preschool:_____

How many days per week?
_____