Little Hands

INSTRUCTIONS

Speech Language Intake

Please download and save this PDF to your computer then fill out with your computer's keyboard using Preview or Adobe Acrobat (no handwritten responses please). Once complete, save the form and attach it to an email to your therapist.

IMPORTANT: This completed intake form and payment of the invoice related to your upcoming evaluation are required at least 1 week prior to your child's scheduled assessment date. If payment is not received within 72 hours of your scheduled evaluation date we will be forced to cancel the evaluation.

Summary of Enclosed Documents

- Speech Language Intake Form (pages 2 to 12) - **fill out**
- Practices & Policies (pages 13 to 16) - **fill out/authorize**
- Credit Card Authorization Form (page 17) - **fill out/authorize**
- Notice of Privacy Practices (page 18)

Questions?

Please email Gabrielle Perelmuter:

Email: gp@littlehandsot.com

Little Hands
500 Tamal Plaza, Suite 527
Corte Madera, CA 94925
www.littlehandsot.com

Person Completing This Form

Full Name

Date

Relationship to Child

Child's Information

Child's Full Name

Referred By

Child's Nickname (if applicable)

Child's Date of Birth (mm/dd/year)

Child's Current Grade

Name of Child's Current School

Child lives with (check one)

- [ ] Both Parents
- [ ] Parent & Step-Parent
- [ ] One Parent
- [ ] Adoptive Parents
- [ ] Other:

Child's Siblings (if applicable - name/sex/age)

Food Allergies (if applicable)

Medications (if applicable)

Restricted Foods (if applicable)

Parent's Information

PARENT 1

Full Name

Occupation

Phone

Email Address

PARENT 2

Full Name

Occupation

Phone

Email Address

Billing Address Information

Street Address

City

State

Zip

Caregiver Information

(Nanny, family members, or others who may drop off/pick up child)

Caregiver Full Name

Caregiver Email Address

Caregiver Phone

Pediatrician Information

Pediatrician Full Name

Pediatrician Email Address

Pediatrician Phone

Clinician(s) Information

(Related to child's diagnosis or therapies)

Clinician 1 Full Name

Clinician 1 Email Address

Clinician 1 Phone

Clinician 2 Full Name

Clinician 2 Email Address

Clinician 2 Phone

Clinician 3 Full Name

Clinician 3 Email Address

Clinician 3 Phone

☐ **I authorize Little Hands to release and exchange information with all clinicians listed above.**

Background Information

Is there a language other than English spoken in the home? ☐ Yes ☐ No

If yes...

What languages?

How often?

Who speaks the language?

Does the child speak and/or understand the language?

Is there a family history of:

Speech/Language Difficulties	☐ Yes	☐ No
Hearing Impairment/Deafness	☐ Yes	☐ No
Learning Difficulties	☐ Yes	☐ No
Developmental Difficulties	☐ Yes	☐ No

If you responded "yes" to any of the above, please describe:

Areas of Concern

Why are you requesting this evaluation?

What questions would you like answered as a result of the evaluation?

Areas of Concern: (check all that apply)

- ☐ Difficulty Expressing Thoughts
- ☐ Difficulty Understanding
- ☐ Immature Language
- ☐ Listening/Hearing
- ☐ Articulation/Speech Intelligibility
- ☐ Speech Fluency
- ☐ Behavioral/Emotional
- ☐ Other:

Please elaborate on areas of concern:

When did you first become concerned?

Has anything changed since your first becoming aware of your concerns?

Has your child ever had a speech/language screening or evaluation?

☐ Yes ☐ No

If yes, please describe:

Has your child ever received speech therapy?

☐ Yes ☐ No

When was your child's hearing last checked?

What were the results?

Has your child received any other evaluation or therapy (e.g., occupational therapy, physical therapy, counseling, etc.)?

☐ Yes ☐ No

If yes, please explain:

Is your child aware of, or frustrated by, any of the concerns listed above?

☐ Yes ☐ No

If yes, please describe:

Birth History

Was there anything unusual about the child's pregnancy or birth?

☐ Yes ☐ No

If yes, please describe:

How was the mother's health during the pregnancy/delivery? Were there any complications, illnesses, and/or accidents that took place?

Please describe:

Was your child:

☐ Full Term

☐ Premature by ____ weeks

What was the length of labor?

What was the baby's birth weight?

Was the delivery induced? ☐ Yes ☐ No

How old was the mother when the child was born?

What was the baby's condition at birth (e.g., healthy, jaundice, breathing problems, etc.)?

Were there any complications at or after birth?

☐ Yes ☐ No

If yes, please describe:

Milestones

Please indicate the age at which your child did the following:

Sat alone:

Crawled:

Stood alone:

Walked:

Toilet-trained:

Cooed:

Babbled:

Spoke 1st word:

What was the first word?

Put 2 words together:

Spoke in short sentences:

Spoke in complete sentences:

Medical History

Has your child had any of the following? (check all that apply)

- [ ] Adenoidectomy
- [ ] Allergies
- [ ] Breathing difficulties
- [ ] Chicken pox
- [ ] Frequent colds
- [ ] Ear infections
  - *How many?*
- [ ] Ear tubes
- [ ] Encephalitis
- [ ] Head Injury
- [ ] Seizures
- [ ] Sinusitis
- [ ] Sleeping Difficulties
- [ ] Thumb/finger sucking Habit
- [ ] Tonsillitis or Tonsillectomy
- [ ] Other:

If you checked any of the above, provide necessary details:

Please describe current health concerns, if any (e.g., illness, ear infections, allergies, etc.):

Please list your child's current medications:

Speech & Language Development

How does your child prefer to communicate? (check all that apply)

- ☐ Gestures/Body language
- ☐ Sounds
- ☐ Words (e.g., doggy, up, eat)
- ☐ 2 to 4 word sentences
- ☐ Sentences longer than 4 words
- ☐ Other:

How many words are in a typical sentence?

Provide 3 sentence examples:

Is your child's speech difficult to understand?

☐ Yes ☐ No

Does your child exhibit speech sound errors?

☐ Yes ☐ No

If yes, what types of errors?

What percentage of your child's speech is understood by:

Familiar listeners (e.g., family members, close friends):

Unfamiliar listeners:

Does your child: (check all that apply)

- ☐ Identify actions/objects
- ☐ Ask questions
- ☐ Follow directions
- ☐ Respond correctly to Yes/No questions
- ☐ Respond to "WH" questions (e.g., what, who)

Does your child understand what is said to him/her?

☐ Yes ☐ No

If yes, how does he/she show you that he/she understands?

Is your child able to adequately express himself/herself?

☐ Yes ☐ No

If no, please describe:

Does your child hesitate, "get stuck", repeat, or stutter in certain situations or with certain sounds?

☐ Yes ☐ No

Describe:

Describe your child's social communication (e.g., how does he/she interact with other children, adults? Does he/she share, take-turns, play alone, etc.):

What opportunities does your child have to play with children his/her age?

Behavioral Characteristics

Do you have concerns related to your child's behavior? ☐ Yes ☐ No

Areas of Concern: (check all that apply)

- ☐ Affectionate
- ☐ Attentive
- ☐ Cooperative
- ☐ Destructive/Aggressive
- ☐ Easily distracted
- ☐ Easily frustrated
- ☐ Happy
- ☐ Impulsive
- ☐ Inappropriate behaviors
- ☐ Plays alone often
- ☐ Plays well with others
- ☐ Poor eye contact
- ☐ Restless
- ☐ Separation difficulty
- ☐ Self-abusive behavior
- ☐ Stubborn
- ☐ Willing to try new things
- ☐ Withdrawn

School History

Name of school:

Current grade:

Teacher's name:

What are your child's strengths at school?

What does your child experience difficulty with at school?

Is your child receiving extra help?

☐ Yes ☐ No

If yes, please describe:

How does your child feel about school?

Additional Information

What are your child's favorite play activites/hobbies/interests (e.g., Legos, video games, reading books)?

Is there anything else about your child that would be helpful for us to know? Please describe.

Practices & Policies

(As of January 1, 2020)

I. RATES

A. First Steps To An Evaluation

Initial Consultation Meeting (Parent Meeting: Optional): $250/session (45 minutes)

Evaluation (At Little Hands Clinic): $195 (45-60 minutes)

Deposit for this evaluation charge is pre-paid in order to reserve the day/time & non-refundable.

Evaluation (At School): $195 (45-60 minutes)

B. Follow Up To Evaluation

(Reports are required before therapy begins)

Evaluation Report: $195/hour

Average time 1-3 hours. Reports are received after payment is made.

Parent Education Meeting: $195/session (45 minutes)

A parent/therapist meeting is required 6 to 8 weeks after initiating weekly therapy.

C. Weekly Therapy

Treatment Session: $155/session (45 minutes - Occupational Therapy)
$160/session (45 minutes - Speech Therapy)

If a child is over 10 minutes late to be picked up, additional charges will be applied as per hourly rate)

Treatment Sessions in Child's School or Home: $195/session (45 minutes)

Consultative Services: $195/hour

These include progress reports, home programs and/or email/phone calls that exceed 10 minutes.

School Observations: $195/hour

May be additional if over 10 miles of driving.

Nutrition/Dietician Services: $195/hour

D. Additional Reports/Re-assessments

Progress Report (every 4-6 months): $195/hour

Average time: 1-2 hours.

E. Parent Consultation Services $250/session (45 minutes)

Behavior plans, implementation of home strategies, school placement, prioritizing therapies, sibling challenges, and public school services consultation (IEP & 504)

II. PROCESS/DESCRIPTION OF SERVICES

All Little Hands Clients are evaluated and follow the below process before treatment to determine rate/type of treatment.

A. Initial Consultation Meeting

(Recommended but optional)

The therapist and parent(s) discuss concerns related to the child's functioning. The therapist provides recommendations for an evaluation, treatment, and/or home strategies.

Cost: $250

B. Evaluation

(Required for treatment)

Approximately 1 to 2 hours of testing using standardized and/or informal measures to assess the child's strengths/weaknesses and determine the need for weekly therapy.

Cost: $195 **(EVALUATION REPORT NOT INCLUDED)**

C. Evaluation Report

(Required for treatment)

Written description of administered tests, the child's performance, and areas to target in treatment (if applicable). This report includes a treatment plan (when treatment is recommended) with baseline areas of functioning and 4-6 month goals.

Cost: $195 per hour (ranges between 2 to 4 hours)

D. Progress Report

(Required for continued treatment at Little Hands OT)

This report describes the child's progress toward targeted goals, his/her current levels of functioning, and the new treatment plan (if continued treatment is recommended). Progress reports are provided every 4 to 6 months (depending on the frequency of treatment sessions). If additional progress summaries are provided (e.g., via email) they will billed in increments of

Cost: $195 per hour

E. Evaluation Feedback Meeting

(Strongly recommended but optional)

The therapist and parent(s) review the evaluation report and treatment recommendations.

Cost: $195 per hour

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F. Consultative Services

(Depending on needs of client)

The therapist provides recommendations and strategies for home and school settings to optimize the child's functioning and address areas of concern. Classroom observations, consult with parents/school staff, and therapy collaboration with other specialists are also commonly provided.

Cost: $195 per hour

G. Treatment Sessions

(Depending on needs of client)

Individual, paired, and small group sessions are available. Co-treatment sessions (speech/language therapy combined with occupational therapy) are also offered when appropriate. Treatment sessions are typically 45-minutes in duration (with the remaining 15 minutes of the hour being used for treatment note-writing and planning).

Cost: $155/session (45 minutes - Occupational Therapy)
$160/session (45 minutes - Speech Therapy)

III. PARKING & PROCEDURES DURING SESSIONS

On-site parking is available. Parents are not **required** to stay at the clinic while their child is participating in therapy sessions or evaluations. We highly value parent participation in sessions although they are not required, please contact your therapist ahead of time (**at least a week**) to arrange for a session **WITH** your child, due to privacy of other families participating at Little Hands.

IV. CANCELATIONS/NO-SHOW'S

There is no charge for cancelled services **due to your child's illness** when **at least 24 hours** notice is given. Otherwise, missed sessions due to child's illness will result in a charge for the full cost of the session. Please notify the therapists of **planned vacations or other conflicts with at least 2 weeks** advanced notice otherwise sessions will be fully charged. Notice of changes in schedule (**sickness and/or vacation must be in the form of email or phone call to therapist**).

V. PAYMENT & INSURANCE

Invoices for therapy sessions are electronically delivered at the end of each month. **Payment is due upon receipt; late fees are applied if payment is not received by the 15th of the month. The full cost of the evaluation write up report is due once the report is complete and invoice is received, prior to receipt of the written report. Report will be provided once payment of report is received.**

If invoices are received late 2 months in a row, Little Hands has the right to request pre-paid monthly invoices for services (payment for upcoming month of services must be received before the 5th of each month). A credit card will be held on file and used in the event of a 30 day past due invoice.

While we provide no direct insurance billing from this office, we are happy to provide you with super bills, which are receipts for therapy services with relevant diagnosis and treatment codes. Periodically, insurance companies may request documentation regarding Occupational Therapy services, and we routinely provide evaluation and updated progress reports as requested by insurance companies. **Preparation of these documents is billed in increments of the treatment rate.**

VI. TERMINATION OF THERAPY

If you terminate therapy, for any reason, we require **at least 2 weeks of sessions' prior written notice** in order for the therapist to transition the child out of therapy and complete closure. We reserve the right to terminate our relationship with a client at any time for any reason. Unless circumstances require otherwise, if we terminate the relationship, we will provide at least 2 sessions' prior notice.

VII. DELINQUENT ACCOUNTS

Invoices will be sent via email at the end of each month to be received by the 1st of each month. Invoices are due upon receipt. **Late fees are applied if payment is not received by the 15th of the month.** Collection of past due accounts

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will be initiated if non-payment of account extends beyond 60 days. A credit card will be held on file and used in the event of a 30 day past due invoice. You will be responsible for payment of reasonable attorney fees and all collection costs, including court costs in the event action is commenced to collect past due accounts. Collection agency fees shall be no less than 35% of the outstanding balance. **If invoice payments are received late 2 months in a row, Little Hands has the right to request pre-paid monthly invoices for services. Payment for upcoming month of services must be received before the 5th of each month.**

VIII. COVID-19 DISCLOSURE, ACKNOWLEDGMENT AND LIABILITY WAIVER

By signing this form, I acknowledge the contagious and still unknown nature of the COVID-19 virus and voluntarily assume the risk that I or my family members (child) may be exposed to or infected by COVID-19 and that such exposure or infection may result in personal injury, serious illness, permanent disability or death. I understand that the risk of becoming exposed to or infected by COVID-19 may result from the actions, omissions, or negligence of myself and others. I voluntarily agree to assume all of the foregoing risks related to COVID-19 and accept sole responsibility for any injury to myself or my invitees, including, but not limited to, personal injury, illness, disability, death, damage, loss, claim, liability, or expense, of any kind, that I or my child/family member may experience or incur in connection with visiting Little Hands for therapy. I hereby release, discharge, covenant not to sue, and hold harmless to Little Hands, their employees, agents, representatives, associates and insurers (collectively "Released Parties"), of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of Released Parties whether a COVID-19 infection occurs before, during, or after my or my child's visit at Little Hands. I acknowledge and agree to take appropriate precautions, including maintaining good personal hygiene including frequent hand washing or sanitizing and staying at least six feet from persons not in my party or related to me. I further agree to make every effort to follow all rules, policies, and safety precautions established by the Centers for Disease Control and Prevention ("CDC"), the California Department of Public Health ("CDPH"), or other State or Federal agency, whether posted in writing or explained to me verbally, and take all necessary steps to reduce the risk of illness to me and my party. I specifically acknowledge and agree to not come to Little Hands if anyone in my family are experiencing any of the symptoms of COVID-19 as identified by the CDC and/or the CDPH including cough, shortness of breath or difficulty breathing, fever, chills, muscle pain, sore throat, or new loss of taste or smell. By signing below, I understand that I am releasing any potential Claims against Little Hands and in return I will be permitted to visit and participate in activities at and around the clinic.

IX. CHANGE IN POLICIES

The terms and conditions in this policy may change from time to time. Such changes will occur with 30 days written notice.

Authorization

☐ I agree to the above policies/practices for my child.

Child's Name:

Your Full Name:

Date:

Availability: (Please specify days/times that your child is available for weekly therapy.)

Authorization for Credit Card Use

All information will remain confidential

BILLING INFORMATION

Name on Card

Billing Address

Billing City

Billing State

Billing Zip

Credit Card Type

☐ Visa ☐ Mastercard ☐ Discover ☐ AmEx

Credit Card Number

Expiration Date

Identification Number

Authorization

☐ I authorize Little Hands Occupational Therapy, Inc. to charge this credit card for late payments on invoices due and payments associated with any documentation, report writing and or consultation which have not been paid in due time according to the practices and policies.

Date:

Notice of Privacy Practices

Treatment: We may use and disclose your child's health information as part of assessment and intervention procedures. In addition, we may use and disclose your child's information with other caregivers, professionals, or persons working with your child, only when given written consent. If a parent/legal guardian would like consultation with other caregivers/professionals/persons, he or she shall sign and submit a Release of Information form.

Billing: We may use and disclose your health information to obtain payment for services we provide to you.

Your Authorization: You may give us written authorization (Release of Information) to use your child's information or disclose it to anyone for any purpose. If an authorization is provided to us for any individual or entity you may revoke the authorization in writing at any time.

To Your Family and Friends: We must use and disclose your child's information to notify your family or any other person responsible for your child's care of your child's location, and/or general condition. If you are present we will provide you with the opportunity to object to such disclosures. Our Transportation Release form only grants permission for an individual to transport your child. If you would like for us to share information with those who may be transporting your child, we require a Release of Information for that individual. We will only provide information to individuals that have been identified on the Release of Information form.

Marketing: We will not use your child's information for marketing purposes without a written release.

Required by Law: We may be required to provide information to law officials under certain circumstances. We are mandatory reporters. We may be obligated to use or disclose your child's information if we believe that your child is a possible victim of abuse, neglect, domestic violence, or the possible victim of other crimes.

National Security: We may be obligated to use or disclose your child's information as required for national security: to military authorities or armed forces personnel, to authorized federal officials as required for lawful intelligence, counter-intelligence, and other national security activities, or to correctional institution or law enforcement official, having lawful custody of health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use your child's information for appointment reminders (i.e. voice mail, reminder cards, post-it notes) In order to ensure adherence to confidentiality policies, email communication will be limited to scheduling. When discussing your child via email, parent/legal guardian is requested not to use his/her child's name in the text (initials or treatment day/time would be acceptable).

Clinic Visits: Occasionally persons (e.g., parents or related service providers) may request to visit the facility or may be participating in a therapy session with their child. These visits will be scheduled only if it is determined not to interfere with a child's therapy session. Should you be attending your own child's therapy session, you are reminded that the identity and other sensitive information of any and all other children and families present in the clinic should be treated with confidentiality, and should not be discussed outside of the clinic.

We reserve the right to change our privacy practices at any time. If we change the privacy practices, we will issue a revised notice of privacy practices.