PATHWAYS SPEECH & LANGUAGE

310-581-6430 Fax 581-6433
3205 Ocean Park Blvd., Suite 120
Santa Monica, Ca 90405

Intake Packet

Patient Information

Patient's Name D. O. B. Gender

Street Address City State Zip Code

Mother's Cell Mother's Email

Father's Cell Father's Email Nanny/Babysitter (if any) Name and Cell

Parent Information

Mother	Father
Mother's Name Age	Father's Name Age
Employer Business Phone	Employer Business Phone
Address of Business	Address of Business
Occupation	Occupation

Referred by Phone	Reason for Referral
Pediatrician/Family Doctor Phone	Current School

Date: Signature:

FOR OFFICE USE ONLY:

Diagnosis:	Additional Information:
Evaluation:	
Therapy:	Therapist:

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Medical History:

1. Has your child experienced any of the following?

- o Vision Problems
- o Hearing Problems
- o Ear Infections
- o Serious Illness
- o Surgeries
- o Hospitalizations
- o Seizures
- o Tubes (if so, when ___/___/___)

If yes, please explain below: ____________________

____

____

____

2. Is your child currently taking any medications (if yes, please list and describe effects) ____________________

____

____

3. Does your child have any known food allergies? (if yes, please list) ____________________

____

4. Is there a family history of communication/neurological or other difficulties? If yes, describe: ____________________

____

____

Developmental History

1. Describe the pregnancy and birth of your child (illness, injuries, difficulties?): ____________________

____

____

2. Was your child full term? If not, please give gestational age: **Y / N Age:** ____________________

3. Circle feeding method. **Bottle / Breast Until Age:** ____________________

Are there any chewing, feeding, or swallowing issues currently? ____________________

____

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4. Does your child: **Use a pacifier? Y / N** **Suck Thumbs/Fingers? Y / N**

5. Is your child potty trained? If yes, completed at age:

6. Please describe your child's eating habits (any restrictions, difficulties, allergies?):

7. Please list any additional therapy services your child has received (occupational, psychological, behavioral, etc.) and the approximate dates attended:

Family and Educational Information:

1. Who does the child live with?

2. Siblings, names, ages:

3. School attended?

4. What kind of difficulties is your child experiencing at school regarding speech, learning, etc.?

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Speech and Language Information

1. What do you feel is the problem? ______________________________

____

____

At what age did your child first:

_______ Babble
_______ Use single words
_______ Say first word with meaning
_______ Use combined words

Does your child experience difficulty with:

- Expressing self?
- Understanding language?
- Producing clear speech?

If yes to any, please describe on the lines below:

____

____

____

____

Does your child experience difficulty with any of the following?

- Memory
- Attention
- Organizing thoughts
- Feeding skills
- Swallowing
- Other ______________________

If yes to any, please describe: ______________________________

____

____

Other comments or concerns? ______________________________

____

____

Thank you!

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Pathways Speech & Language

A Professional Corporation

Policies and Procedures

- Therapy sessions are 50 minutes; please be in the waiting room 5 to 10 minutes before the end of your child's session
- Appointments must be canceled 24 hours before the appointment day
- Failed appointments and cancellations after the above mentioned time frame will be billed at the regular rate in addition to a $35 fee
- If your child appears to be ill in any way - please cancel his/her appointment
- Request progress reports for medical evaluations or school IEP meetings at the earliest possible advanced notice
- Provide the earliest possible advanced notice for scheduling our attendance at IEP meetings
- IEP, school visits and parent conferences are charged at the therapy session rate
- All insurance reports will be submitted upon receipt of written request from the insurance company

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Parking

Unfortunately, there is no parking for our patients in the parking lot. You may park on Ocean Park Boulevard and 32nd Street in metered or non-metered spaces. Please note the street sweeping signs on 32nd Street. Thank You.

Speech pathology services are provided for the patient with the understanding that payment for such services is the responsibility of the patient, parent or guardian. Payment is expected at the time of service or on a weekly basis if seen more than once a week. We make no express or implied representation that your insurance company will in fact recognize speech pathology services unless services are already authorized. Accounts more than 30 days past due will accrue finance charges at the rate of 1½ % per month until payment is made in full.

Repeated no-show or late cancellations take valued appointment slots for others, and if frequent, may result in dismissal from the schedule.

Billable charges are as follows:

- Therapy sessions
- Failed appointments and late cancellations, with an additional $35 fee
- Parent Conferences
- School visits
- IEP meetings
- Team meetings
- Reports
- Scheduled phone conferences
- Copying and mailing of insurance packets

I have read and agree to these policies.

____ __________________

Signature Date

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CONSENT FOR EMERGENCY MEDICAL TREATMENT

In case of an emergency, and if I, the parent or legal guardian of ________________________

(child's name), am not present, I give permission to the personnel of Pathways Speech & Language, P.C., into whose care our child has been given, the authority to consent to an x-ray examination, anesthetic, medical or surgical treatment and hospital care to be rendered under the supervision and upon the advice of a physician and surgeon licensed under the provisions of the Medical or Dental Practice Act.

In the event of a medical emergency and I, the child's parent or guardian, am not on site, hereby understand that the staff of Pathways Speech & Language, P.C. will contact 911 of other appropriate medical personnel. If ambulance service must transport my child, I understand that it will be to the closest medical facility able to handle the situation.

I understand that my child's records are protected under state and federal confidentiality regulations and cannot be disclosed without prior written consent. I give my consent to allow the release of information and/or records/reports regarding my child for purposes of emergency medical treatment.

The staff of Pathways Speech & Language P.C., will not be liable for any first aid treatment, medical or hospital care rendered, or drugs, medicine or surgical procedures performed pursuant to this consent.

____ ____________

Signature of Parent or Guardian Date

Please provide the names and telephone numbers of closest friends and relatives:

Emergency Contact 1, First and Last Name	Relationship
Home Telephone	Work Telephone
Emergency Contact 2, First and Last Name	Relationship
Home Telephone	Work Telephone

My child is covered under the following health insurance policy: _________________________

I
nsured's Name______________________________ I.D.No: ________________________

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CONSENT FOR RELEASE OF INFORMATION

I understand that my records are protected under state and federal confidentiality regulations and cannot be disclosed without prior written consent. This is the case except where life or safety is seriously threatened, or where required by law, as in: threats or acts suggestive of suicide, homicide, child/elderly abuse, or in situations involving individuals with grave disability.

I give my consent to allow the release of information and/or records/reports regarding the following patient:

Name:______________________________ DOB:____________________

□ To: Pathways Speech & Language, P.C.

□ From:
- [ ] Dr_____________________________________
- [ ] OT_____________________________________
- [ ] PT_____________________________________
- [ ] Teacher_________________________________
- [ ] Other___________________________________

□ To: ______________________________

□ From:
- [ ] Dr_____________________________________
- [ ] OT_____________________________________
- [ ] PT_____________________________________
- [ ] Teacher_________________________________
- [ ] Other___________________________________

Patient/Parent/Guardian Signature: ________________________ Date:__________________

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Informed Consent for Videotaping

I understand that therapy treatments at Pathways Speech & Language, P.C. may include periodic videotaping. The purpose of videotaping is to help monitor, document, and enhance the child's progress. The videotapes are kept at Pathways Speech & Language, P.C. and are reviewed and used only by the staff. Parents are welcome to watch their child's videotape; occasionally (and only at you explicit request), a viewing can be arranged for another of your child's professionals.

□ I give consent for my child to be videotaped. I understand that its use and observation are restricted exclusively to the personnel at Pathways Speech & Language, P.C.

□ I do not give my consent.

Informed Consent for Use of Therapy Equipment

I understand that my child ____________________________________, will be involved in therapeutic activities which may involve the use of specialized equipment such as suspended equipment and various swings, large therapy balls, tactile or touch media, and fine motor, oral motor and eye-hand coordination activities. I have been informed by the staff of Pathways Speech & Language, P.C. regarding the nature of, as well as the risks associated with the use of this equipment and these activities.

□ I give permission that my child may engage in the used of the various therapeutic activities described above.

□ I do not give permission.

______________________________________ ________________

Signature of Parent or Guardian Date

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August 1 2017

ATTENDANCE AND CANCELLATION POLICY

Our experience has shown that consistent attendance is the key to good progress and success in reaching your child's goals. Whether you are here once or twice weekly, it is necessary to make a commitment to keep that scheduled appointment. Other activities may have to be rescheduled to make that possible.

If you do have to cancel, it is vital that you reschedule that appointment with either your regular therapist or another available therapist. We have made every effort to make easy transitions to a substitute; in many cases it is actually an excellent opportunity to practice with a less known listener and helps generalize the skills being learned.

We are unable to hold appointment times for extended absences; for instance, more than two weeks vacation. If you are going to be gone for a longer period, arrangements should be made with the director if you wish to reserve your appointment time.

Cancellations must be made 24 hours before the scheduled appointment. Our voice mail will time and date stamp your call. E-mail is not an acceptable way to cancel; we cannot guarantee that the office or your therapist will check it in time. If your child is ill please let us know as soon as possible. Late cancellations and failed appointments will be billed as a regular session, along with a required $35.00 fee.

Thank you for your consideration. We love our pathways families!

Gayle Keefer, M.A.

Director

Pathways Owner

Signature of Parent or Guardian

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