BILINGUISTICS

NEW PATIENT INTAKE FORM

Thank you for trusting Bilinguistics to evaluate and treat your child. Please provide your child's medical history and your concerns about his/her communication.

PATIENT INFORMATION

First and Last Name: _____

Date of Birth: _____ Age: _____

Parent/Guardian Name: _____

Parent/Guardian Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Best Contact Number _____

Can we contact you via email? □Yes □ No If yes, email Address: _____

Whom does your child live with? □Mother □Father □Sibling(s) age(s): _____

□ Extended family: grandparent, aunt, uncle

Does your child attend daycare, preschool or school? □Yes □ No

If yes, where? _____ What grade? _____

Pediatrician Name: _____

Pediatrician Phone Number: _____

Practice Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

PRIMARY INSURANCE/MEDICAID INFORMATION

Insurance Name: _____

ID/Member ID: _____

**** Please provide a copy of your insurance card. ****

HIPAA COMPLIANCE

I understand that as part of the provision of healthcare services, BILINGUISTICS, INC. creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information.

I understand that I have the right to review the notice prior to signing the consent. I understand that the organization reserves the right to change their Notice and practices prior to implementation and will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting, or arranging for medical review, legal services, and auditing functions, etc.). The organization is not required to agree to the restrictions requested.

By signing this form, I consent and authorize clinicians with BILINGUISTICS, INC. to disclose treatment records, assessment reports, progress notes, and any other information necessary to the patient's school and physician or any other person or entity that would assist in payment, and health care operation. I have the right to revoke this consent, in writing, except where disclosures have already been made on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment, or health care operations without my prior written authorization, except otherwise provided by law.

2. A photocopy or fax of this consent is as valid as this original.

3. I have had the right to request that the use of my Protected Health Information, which is used or disclosed for purposes of treatment, payment, or health care operations, be restricted. I also understand that the Practice and I must agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information, which have been previously agreed upon.

_____

Parent/Guardian signature Date

MEDICAL/DEVELOPMENTAL HISTORY

Was your child born full-term?	□ Yes □ No
Were there complications during pregnancy? If so, please explain:	□ Yes □ No
Were there complications after birth (e.g., NICU stay, etc.)? If so, please explain:	□ Yes □ No
Does your child have a history of major medical illness, injury or surgery?	□ Yes □ No
Has your child been diagnosed with a medical condition? If so, please explain:	□ Yes □ No
Does your child take any medications?	□ Yes □ No
Does your child have any allergies?	□ Yes □ No
Does your child have any eating difficulties (including picky eater)?	□ Yes □ No
Do you have any concerns with your child's behavior? If so, please explain:	□ Yes □ No
Does your child have any sleeping difficulties?	□ Yes □ No
Has your child had a recent hearing screening?	□ Yes □ No
Does your child have a history of ear infections/PE tubes?	□ Yes □ No
Do you have any concerns with your child's hearing or vision? If so, please explain:	□ Yes □ No
Are there any speech, language, learning or hearing problems in your family? If so, please explain:	□ Yes □ No
Has your child had any previous evaluations?	□ Yes □ No
Does your child currently receive any specialized services?	□ Yes □ No
Has your child received specialized services in the past?	□ Yes □ No
Does your child use an assistive communication device?	□ Yes □ No

Does your child experience any sensory difficulties such as:

- □ sensitivity to loud noises/covering ears
- □ sensitivity to light
- □ sensitivity to haircuts or having their teeth brushed
- □ inability to tolerate having dirty hands
- □ inability to tolerate certain food or clothing textures?

SPEECH/LANGUAGE QUESTIONNAIRE

What is your main concern with your child's communication?

Describe how your child communicates.

□ cries
□ grunts
□ uses single words
□ uses two-word combinations
□ uses sentences with some errors
□ points or gestures
□ makes different sounds (babbles)
□ uses simple 3-4 word combinations
□ uses grammatically correct sentences

At what age did your child begin to babble?

At what age did your child begin to use single words?

At what age did your child begin to use combined words?

When you talk to your child, how much does he/she understand?

□ a few words
□ single directions
□ almost everything I say
□ He/She is non-responsive
□ many words/phrases
□ simple questions
□ everything I say

Does your child have difficulty with certain sounds? □ Yes □ No

If yes, please explain:

Please give an example of how your child speaks. If your child does not yet speak, please describe how your child communicates his/her wants and needs.

Does your child have any difficulties with stuttering, such as repeating sounds, syllables, or words?

What other language(s) is your child exposed to other than English?

Overall, what language do you feel your child **UNDERSTANDS** the best?

What language do you feel your child **SPEAKS** the best?

What percentage of the time do you feel your child **HEARS** his/her languages?
(For example, 80% Spanish, 20% English)

What percentage of the time do you feel your child **SPEAKS** his/her languages?
(For example, 80% Spanish, 20% English)

AGREEMENT

I hereby agree to the following:

□ I have completed the New Patient Form to the best of my knowledge.

□ I agree to notify Bilinguistics, Inc. of any changes in insurance and/or primary care provider immediately.

□ I agree that I have insurance coverage with my insurance company and assign directly to Bilinguistics, Inc. all medical benefits, if any, otherwise payable to me for services rendered.

□ I agree to authorize the release of any information necessary to secure payment of benefits.

□ I authorize the use of this signature on all insurance submissions whether manual or electronic.

_____

Parent/Guardian signature Date

CONSENT FOR EVALUATION AND TREATMENT

I hereby agree to the following:

- ☐ I request that Bilinguistics, Inc. complete a comprehensive speech and language evaluation.
- ☐ I request that Bilinguistics, Inc. provide treatment as prescribed by a speech-language pathologist.
- ☐ I acknowledge and agree that a parent or legal guardian must be in the home for teletherapy sessions or in-person in the waiting room area of the office during each treatment session.
- ☐ I understand that all information shared with the clinicians is confidential and no information will be released without my consent.
- ☐ I understand that my consent is voluntary and that I may stop treatment at any time.

I have read and understand the terms.

_____

Parent/Guardian signature Date

GRADUATE STUDENT OBSERVATION/CLINICAL

Bilinguistics partners with universities to place graduate students in our clinic for observation and to complete clinical hours.

☐ I am ok with a student observing my child's sessions.

☐ I prefer NOT to have a student observe my child's sessions.

_____

Parent/Guardian signature Date

MISSED SESSIONS/CANCELLATION POLICY

I hereby understand and agree to the following:

We request that you notify us 24 hours prior to your appointment if you need to cancel or reschedule. Failure to call or be present for an appointment whether in-person or virtually is considered a missed appointment.

Bilinguistics, Inc. will charge a fee of $45.00 for all appointments canceled after 8:00 a.m. on the morning of the appointment.

The fee of $45.00 applies for all missed appointments.

Please note that insurance providers do NOT reimburse for missed appointment charges.

If your child misses 3 sessions without prior notice OR has 3 consecutive cancellations, Bilinguistics, Inc. reserves the right to discharge your child from speech therapy. *A consistent schedule is pertinent to your child's progress in speech-language therapy. Please help us serve you better by keeping scheduled appointments.*

_____

Parent/Guardian signature Date

TARDINESS

I hereby understand and agree to the following:

We expect patients to be on time for their appointments. If you are running late for an appointment, either virtual or in-person, and are more than 7 minutes late, your appointment will be canceled. **There is a no-show fee of $35.00.**

_____

Parent/Guardian signature Date

ILLNESS POLICY

I hereby understand and agree to the following:

If your child has a fever, a persistent cough, or a runny nose, please cancel your appointment.

A general rule of thumb is that if a child has been on an antibiotic for 24 hours and does not have a fever, is not coughing frequently, and does not have a runny nose, he/she is probably not contagious.

We appreciate your understanding and will be happy to reschedule your appointment. You may leave a voicemail message on our office line 512-480-9573. We appreciate notice of cancellation as soon as possible; however, we also understand how illness in young children can occur suddenly, so you will not be penalized with a fee if you call and cancel for sudden illness.

_____

Parent/Guardian signature Date

CREDIT CARD AUTHORIZATION FORM (REQUIRED)

CARDHOLDER NAME:		
BILLING STREET ADDRESS:		
CITY:	STATE:	ZIP:
MASTERCARD VISA	AMEX	
CARD NUMBER	EXP DATE	CVV

I authorize BILINGUISTICS, INC. to charge the credit card above for agreed upon services.

I understand that my information will be kept on file to process future transactions for services rendered.

I understand that BILINGUISTICS, INC. will charge my card after each session.

BILINGUISTICS, INC. must be notified of any changes to the method of payment.

_____

Cardholder Signature Date

Patient Name: DOB: