TOTH Speech Services

20283 St Rd 7, Suite 102
Boca Raton, FL 33498
+1-561-400-1931

Pediatric Intake Form

PATIENT'S NAME: _____

DATE OF BIRTH: ___/___ /_____

HOME ADDRESS:_____

CITY, STATE, ZIP _____

Parent #1/Legal Guardian:_____ Occupation:_____

Employer:_____ Phone:_____

Parent #2/Legal Guardian:_____ Occupation:_____

Employer:_____ Phone:_____

PHYSICIAN NAME: _____

ADDRESS:_____

CITY, STATE, ZIP _____

PHONE # _____

Name of other Specialists

NAME/AGENCY: _____

ADDRESS:_____

CITY, STATE, ZIP _____

PHONE # _____

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NAME/AGENCY: _____

ADDRESS:_____

CITY, STATE, ZIP _____

PHONE # _____

Social Experiences

If the child has siblings living in your household, please complete the following:

Name: Age: Relationship to the Child:

_____

_____

_____

Describe how the client gets along with the following:

Mother:_____

Father:_____

Siblings:_____

Parent's Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Separated/Not Divorced ☐ Widowed ☐ Domestic Partnership

Please describe history of family since the birth of the patient (moves, traumas, changes):

_____

_____

_____

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Emergency Contact

NAME: _____

ADDRESS:_____

CITY, STATE, ZIP _____

PHONE # _____ RELATIONSHIP:_____

Prenatal History:

Mother's Pregnancy: ☐ Normal ☐ Complications:

Gestation: _____weeks

Delivery: ☐ Vaginal ☐ C-Section ☐ Induced - Complications: ☐No ☐Yes

Previous pregnancies: _____

Medical History:

Has your child experiences any of these illnesses – currently or in the past?

☐ Asthma	☐ Measles	☐ Chicken Pox	☐ Tubes in Ear	☐ Frequent Colds
☐ Allergies	☐ Pneumonia	☐ Seizures	☐ Ear Infections	

Please describe any other significant medical information:

_____

_____

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Has a neurologist seen the patient? ☐ YES ☐ NO

Date of last visit: ___/___ /_____

If you answered yes, please provide Neurologist's name and results:

_____

_____

Has the patient's vision been tested? ☐ YES ☐ NO

Date of last visit: ___/___ /_____

If you answered yes, please provide Opthamologist's name and results:

_____

_____

Has the patient's hearing been tested? ☐ YES ☐ NO

Date of last visit: ___/___ /_____

If you answered yes, please provide Audiologist's name and results:

_____

_____

List any medications taken regularly:

_____

List any other illnesses or medical conditions of concern:

_____

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Developmental History:

Condition of newborn (apgar scores, weight and height):

_____

_____

Feeding (method, eating patterns, preferences, difficulties):

_____

_____

Sleep (patterns, naps, problems):

_____

_____

Activity level (reaction to being moves, degree of activity, child's favorite activity):

_____

_____

Is your child toilet trained? ☐ YES ☐ NO

At what age did your child toilet train? _____

Can your child indicate his/her bathroom wishes? ☐ YES ☐ NO

Please describe any concerns you have about your child's toileting:

_____

_____

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At what age did your child first: Roll _____ Sit up _____ Crawl _____ Walk _____

Drink from a cup _____ Talk _____ Use spoon to feed self _____ Run_____

Dressed self _____ First words _____ 2 word sentences _____ 3-4 word sentences _____

Asked questions _____ Answered questions _____

Please describe general fine motor and gross motor coordination:

_____

_____

Please describe current ability to communicate:

_____

_____

Please describe any behaviors of concern or problems (head banging, temper tantrums, rocking, holding breath etc.):

_____

_____

Educational History:

Did your child attend/currently attending Preschool? ☐ YES ☐ NO

Name of Preschool: _____ Age Started: _____

Name of Current School: _____ Grade: _____

Name of Teacher: _____

Type of classroom (structured, open etc.): _____

Teacher's comments about your child: _____

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Please describe your child's performance at school (behavioral, socilaization, play patterns etc.):

_____

_____

Does your child enjoy school? ☐ YES ☐ NO ☐ N/A

Please list and class/classes he/she especially like: _____

_____

Please list and class/classes he/she especially dislikes: _____

_____

Check any areas of difficulty or concern for your child:

☐ Reading	☐ Conduct	☐ Completing work	☐ Writing
☐ Math	☐ Physical Education	☐ Playground time	☐ Social skills

Do you feel your child can organize work adequately? ☐ YES ☐ NO ☐ N/A

Please list prestent and previous school assistance: _____

_____

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Speech-Language Skills/History:

Has there been a speech language evaluation performed? ☐ YES ☐ NO

If you answered "YES" who and where was the evaluation completed? _____

_____

Please describe the results of the evaluation (include attachment):

_____

_____

May we contact the evaluator? ☐ YES ☐ NO

If you answered "YES" please include name and phone number on Designated Individuals Form

_____

How would you describe the patiet's current language skills? Please check one:

☐ Non-Verbal	☐ Few Words (Inconsistent)	☐ Appropriate to relay messages (not typical in peers)

How would you describe the patiet's current language skills? Please check one:

☐ Intelligible for everyone	☐ Intelligible for family members	☐ Unintelligible

Is there any other information you feel would be helpful for us to know: _____

_____

Parent's goal for therapy: _____

_____

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The above information is true and completed to the best of my knowledge:

Parent Signature: _____ DATE: ___/___/_____

Print Name: _____

Notice of Privacy Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU OR YOUR CHILD MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

TOTH SPEECH SERVICES', LLC LEGAL DUTY

Toth Speech Services, LLC is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Toth Speech Services, LLC uses your personal health information primarily for treatment, conducting internal administrative activities and evaluating the quality of care that we provide. For example, we may use your personal health information to contact you to provide appointment reminders, or for information about treatment alternatives or other health related benefits that could be of interest to you.

Toth Speech Services, LLC may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, or for research studies and for emergencies. We also provide information when required by law.
In any other situation Toth Speech Services' LLC policy is to obtain written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at that time.

Toth Speech Services, LLC may change its policy at any time. When changes occur, a Notice of Information Practices will be provided to you. You may also request an updated copy of our Notice of Information Practices at any time.

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PATIENT'S INDIVIDUAL RIGHTS
You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in an emergency circumstance. Toth Speech Services, LLC will consider all such requests on a case-by-case basis but is not legally required to accept them.

CONCERNS AND COMPLAINTS
If you are concerned that Toth Speech Services, LLC may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, you may send a written complaint to the US Department of Health and Human Services.

YOU MAY KEEP THIS NOTICE FOR YOUR RECORDS

PATIENT'S NAME: _____

DATE OF BIRTH: ___/___ /_____

Medical Practice Acknowledgement of Receipt of Notice of Privacy Practices
I certify that I have received a copy of the Notice of Privacy Practices. This Notice of Privacy Practices describes the types, uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Toth Speech Services' health care operations. This Notice of Privacy Practices also describes my rights and duties with respect to my protected health information.

Toth Speech Services, LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

Parent Signature: _____ DATE: ___/___/_____

Print Name: _____

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Designated Individuals Form

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, the treatment of my family member, or of the hereby stated legally represented for payment or administrative operations or as it relates to evaluation and treatment. I understand that I have the right to know at all times what information is shared. I understand that the identity of the designated parties must be verified before the release of any information. I know that I have the right to revoke this authorization at any time in writing.

CLIENT'S NAME: _____

DATE OF BIRTH: ____/____/_____

Authorized Designees: Toth Speech Services, LLC (and treating therapists of Toth Speech Services, LLC)

****Referring Physician is Mandatory:**

PHYSICIAN NAME: _____

Address to where information should be sent:

_____

CITY, STATE, ZIP _____

PHONE # _____

Type of information released: _____

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On the following lines, please write in name of school, teacher, and other treating physicians or therapists if applicable.

NAME: _____

Relationship to patient: _____

Address to where information should be sent:

_____

CITY, STATE, ZIP _____

PHONE # _____

Type of information released: _____

NAME: _____

Relationship to patient: _____

Address to where information should be sent:

_____

CITY, STATE, ZIP _____

PHONE # _____

Type of information released: _____

Signature: _____ DATE: ____/____/_____

Print Name: _____

Relationship to patient: _____

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SCHEDULING POLICY

The therapists at Toth Speech Services, LLC are here for you and want to help you in the most effective and efficient ways possible. We take great pride in providing natural environment therapy services and kindly ask that you consider our travel time when we are coming to your home, school or like environments to provide our professional services. Therefore, it is your responsibility to be on time for your scheduled appointment. Since many of our therapists are on the road all day throughout the SE FL area, we often cannot account for traffic issues or therapy appointments that may run over before your scheduled session. As a result, our therapists try their best to be on time. It is similar to when you go to see your physician and often have to wait in the waiting room until your doctor is ready to see you. Please be advised that should you decide to leave the appointment location due to your therapist's late arrival; you will be charged for the session. In these situations, we will do our best to text or call you to advise you of the backup. However, we still plan for our client's session and travel to you as if the session took place. Thus, we need to compensate our therapists. We appreciate your understanding in this sensitive matter. We look forward to working with you and are glad you are here.

Regards,
Maria E. Toth, MS, CCC-SLP

Patient Name (print) _____
Patient Signature (or parent) _____
If patient is unable to sign, please indicate your relationship to patient:
_____

Date of Signature: ___/___/_____

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Media Release Form

I, _____am the parent/guardian of _____ (referred to as "my child"), and participate in therapy services with Toth Speech Services, LLC.

I hereby consent to the taking of photographs and videos of him/her on behalf of Toth Speech Services, LLC. I also grant the right to edit, use and reuse said products for non-profit, non-commercial purposes, including in print, online, social media and all other forms of media. This includes sharing with parents to document child's progress. I give this authorization without expectation of compensation.

This consent will remain in effect until I revoke it in writing.

CHILD'S NAME: _____

PARENT/GUARDIAN SIGNATURE: _____

PRINT NAME: _____

RELATIONSHIP TO CHILD: _____

DATE: ___/___ /_____

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Agreement to Receive Services at School

I hereby give permission to **Toth Speech Services, LLC** and their therapists, to provide Speech Therapy at my child's school. I also authorize Toth Speech Services, LLC to give and receive information to staff for the care of my child. The information includes but not limited to my child's progress, plan of care, observation done during sessions, and scheduling.

CHILD'S NAME: _____

DATE OF BIRTH: ___/___ /_____

PARENT/GUARDIAN SIGNATURE: _____

PRINT NAME: _____

RELATIONSHIP TO CHILD: _____

DATE: ___/___ /_____

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Credit Card Payment Authorization Form

ALL Toth Speech Services, LLC clients are required to keep a credit or debit card on file for payment services as a backup payment method should your account go into outstanding balance status. Our system enables us to maintain your information securely and only accessed under the terms you specify below. Form completion allows Toth Speech Services, LLC permission to automatically charge your credit card each session for the amount due for services to be rendered, should credit or debit card be your chosen method of payment. If the credit card info we have on file changes, you must notify us ASAP.

*Any account that defaults due to an expired/invalid card will be charged a late fee of $25 every 5 days until the account is updated.

For HSA card users, please authorize charges ahead of time with your HSA company, as TSS will not be held responsible for denied charges once completed. If you have any questions about a charge, please notify us within 15 days. After that time, all charges will be assumed to be correct. We will maintain clear record of all payments and charges. However, in the rare case that an overpayment occurs, your account will be credited on the upcoming invoice or if the balance is zero and you have taken a break from therapy a reimbursement can be applied to the card. A receipt will be sent to you from Intuit (our credit card processing company). Scheduled sessions resulting in a "no show" or cancelled less than 48 hours before the session will be charged at a rate of $85.00 or one session for clients who purchase a package of services. One cancellation (excluding "no shows") within a 24-hour period due to emergency or illness will be allowed at no charge once every 3 months. Phone calls with our therapists are complementary up to 10 minutes in length and after 10 minutes billed at $5.00/minute. Therefore, it is recommended that lengthy conversations take place during session time only or that a follow up session be scheduled. One year after initial evaluation, a mandatory re-evaluation will be scheduled for $225.00 for all clients. Sometimes, insurance companies require these re-evaluations to be completed every six (6) months. In that case, the cost will be $175.00.

*A 3.5% service fee will be charged to each transaction.

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I HAVE READ AND UNDERSTAND THE CREDIT CARD ON FILE AGREEMENT AND AUTHORIZE TOTH SPEECH SERVICES, LLC TO CHARGE MY CREDIT CARD AS STATED ABOVE.

CLIENT'S NAME: _____
DATE OF BIRTH: ____/____/_____
EMAIL: _____

CARD TYPE:

☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS ☐ DISCOVER
☐ OTHER: _____

Cardholder's Name: _____
Card Number: _____
CVC Number: _____ (3 or 4 digits on the back)
Expiration Date: ____/____

BILLING ADDRESS (where you receive statements):
_____
_____
_____

Cardholder's Phone: _____

CARDHOLDER'S SIGNATURE

X_____ DATE: ____/____/_____

Print Name: _____