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PARENT QUESTIONNAIRE

Child's Name: _____ **Date of Birth:**_____**Today's Date:** _____

▫Male ▫Female

- **Parent/Guardian:** _____ **Occupation/Employer:** _____
  Email:_____
  Home Ph. #: _____ **Cell Ph. #:**_____ **Work Ph. #:**_____

- **Parent/Guardian**_____ **Occupation/Employer:** _____
  Email:_____
  Home Ph. #: _____ **Cell Ph. #:**_____ **Work Ph. #:**_____

Responsible Party's Address:_____

Street **City/State** **Zip Code**

Are the *biological* parents **different** from the above mentioned: ☐Yes ☐No Comments:_____

Sibling(s) name and age: _____

Emergency Contact Name/Relationship: _____**Emergency Contact Number:**_____

Referred by: _____**Current Concerns/Reason for Referral:**_____

What is your goal for therapy?_____

CURRENT CONDITION

Is your child currently taking any medications? ☐Yes ☐No

if "yes" please list medication name, dosage, and frequency_____

Allergies (foods, medications, environment, etc)_____

Does your child sleep / nap well? ☐Yes ☐No ☐Sometimes Comments:_____

Does your child participate in age appropriate movement activities? (riding a bike, skipping, jumping)

☐Yes ☐No ☐Sometimes Comments:_____

Does your child currently or have a history of Reflux? ☐Yes ☐No Comments:_____

MEDICAL INFORMATION/HISTORY

Primary Care Physician: _____ **Physician Phone:** _____**Physician Fax:** _____

Is there a family history of speech-language delays/disorders, learning disabilities, or other developmental delay?

☐Yes ☐No Comments:_____

Does your child currently see other Specialists? (Physicians, Counselors, Tutors, etc): *please list name and contact number. Also please list previous therapies or services your child has received and the approximate dates he/she received them.*_____

_____

History of any major illnesses or hospitalizations?_____

Are there any diagnosed mental, physical or emotional disabilities? _____

History of ear infections? ☐Yes ☐No if yes, were tubes placed? ☐ Yes ☐ No When? _____

Has your child had a formal hearing evaluation? ☐Yes ☐No Where? _____ Results_____

Has your child had a formal vision examination? ☐Yes ☐No Where? _____ Results_____

EDUCATIONAL/SOCIAL HISTORY

School:_____ Grade:_____

Special Education Services: ☐ yes ☐ no

What activities does your child enjoy?_____

How does your child interact with others?(out-going, friendly, shy, aggressive, cooperative)_____

DEVELOPMENTAL HISTORY

MATERNAL HISTORY

Pregnancy was: ☐Normal ☐ Difficult

If problems occurred, what kind (circle all that apply) vaginal bleeding chronic disease viral infection

Rh incompatibility toxemia hypertension trauma accident false labor other:_____

Length of pregnancy:_____ Length of Labor:_____

Were there any drugs or medication taken during the mother's pregnancy? ☐ Yes ☐ No Comments:_____

CHILDS BIRTH

Birth Weight_____ Any other complications: (circle all that apply) Cesarean baby rotated jaundiced

premature (# of weeks)____ Rh-negative transfused breech cord around neck twin (1st born, 2nd born)

Special care needed after birth (oxygen, incubator, tube feedings, surgery)_____

Was your child admitted to the Neonatal Intensive Care Unit (NICU)? ☐Yes ☐No

Length of hospital stay:_____

DEVELOPMENTAL MILESTONES

Please list what age **(in months)** that your child achieved the following:

Roll _____ Sit unsupported _____ Crawl_____ Walk_____ Go up/down stairs_____ Run_____

Dress Independently_____ Does/Did your child "W" sit? □Yes □No

Begin putting two or more words together_____ Saying first words _____ Finger feed _____Use spoon _____

Drink from cup _____ Babble_____ Say Sentences_____

Do you feel your child has lost any skills? □Yes □No If yes, what skills and when were they lost?_____

_____

At what age did your child gain bowel control?_____Bladder Control?_____

FEEDING / ORAL MOTOR HISTORY

Was your child breast fed? □Yes □No Comments:_____

Was your child bottle fed? □Yes □No Comments:_____

Does your child **currently** suck on a pacifier or thumb/fingers? □Yes □No Which one?_____

Does your child have a **history** of sucking on a pacifier or thumb/fingers? □Yes □No Which one?_____

Does your child demonstrate any of the following difficulties with feeding/oral motor skills? (check all that apply)

□ Over-stuffs their mouth with food □ Gags/Vomits during feedings □ Frequently Drools □ Strong food preferences

□ Limited Diet □ Special Diet □ Avoids face washing / tooth brushing □ Difficulties with chewing skills

□ Food/drink spillage from their mouth □ Difficulties using cup and/or straw

□ Food texture preferences

(if so,please describe; crunchy, smooth, warm, cold, etc.)_____

SPEECH AND LANGUAGE CONCERNS

What language(s) does your child speak? _____

What language(s) are spoken in the home?_____

Current Concerns: (check all that apply)

□ My child is difficult to understand.

□ My child has difficulty communicating his/her thoughts verbally/clearly.

□ My child has difficulty following directions, understanding concepts/commands.

□ My child appears to not hear what people are saying.

How does your child communicate with you and others? (gestures, single words, sentences)_____

_____

Additional concerns (not listed above) regarding your child's speech and language development?_____

_____

SELF HELP SKILLS: (circle one) Comment

Dressing:

Socks/Shoes	*Independently*	*With Help*	_____
Shirt	*Independently*	*With Help*	_____
Pants	*Independently*	*With Help*	_____
Tying Shoes	*Independently*	*With Help*	_____
Fasteners	*Independently*	*With Help*	_____
Toileting	*Independently*	*With Help*	_____
Bathing	*Independently*	*With Help*	_____
Tooth Brushing	*Independently*	*With Help*	_____
Dresses in a timely manner	*Independently*	*With Help*	_____

Feeding:

Use of a cup	*Independently*	*With Help*	_____
Use of a fork	*Independently*	*With Help*	_____
Use of a spoon	*Independently*	*With Help*	_____

Sensory Concerns: (check all that apply to your child)

□ Avoids/irritated by certain clothing textures □ Mouths objects or clothing □ Hurts self or others (hit, bite)

□ Loses balance/falls or trips often □ Resists participating in movement activities

□ Makes clicking or humming sounds □ Seems to crave movement or can't sit still

□ Bumps into objects/people often □ Tires easily □ Spins or rocks body

□ Has a floppy body or is double jointed □ Is clumsy or awkward in movement □ Toe-Walks

□ Grinds/Clenches teeth □ Is physically rough with people and objects

□ Flaps hands, claps, jumps, hops, stamps to an unusual degree □ Bangs head

□ Stares at mirrors, corners, or wheels □ Enjoys organizing or cleaning tasks

□ Pulls on objects clenched in teeth □ Presses or bangs heels or wrists □ Climbs in inappropriate places

□ Pushes or leans heavily against people or furniture

□ Difficulty with transitions between activities, places, people □ Unpredictable emotional outbursts

□ Slow to recover or hard to calm when upset

□ Distractible, short attention to task □ Hypersensitive to touch, sound, smell, light, or pain

□ Makes repetitious 'vocal' sounds □ Difficulty orienting to others, activity

□ Does not respond to pain, touch, sound, smell, light

□ Delayed response to social communication or sensation (pain, touch, sound, smell, light)

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I hereby authorize Language & Movement to release medical information to my private insurance carrier as is required for determination of benefits. I also authorize payment of medical benefits to the undersigned physician or supplier for services described below.

- _____

Signature of legal representative of child Date

I also allow the release of my child's medical information to the following physicians and/or additional professionals indicated:

Physicians Name:_____ Additional Professional Name:_____

This authorization is valid for the duration of my child's treatment from the date signed below. I understand that I may revoke this authorization at any time, but will not hold Language & Movement responsible for already releasing information in good faith. Language & Movement is released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

- _____

Signature of legal representative of child Date

CONSENT FOR CARE AND TREATMENT: As the child's parent or legal guardian, I hereby grant permission for the licensed therapists at Language & Movement to render to my child routine therapeutic care including evaluations, therapeutic activities, educational activities, and other procedures and/or treatments prescribed by my child's therapist as is necessary in their judgment. I understand that my child is under the care and supervision of my therapist.

- _____ _____

Signature of legal representative of child Date

CONSENT FOR TREATMENT DISCUSSIONS/OBSERVATION: I understand that the Language & Movement team will discuss personal and private or sensitive information in the appropriate settings. For otherwise general discussions, it is customary that we do so in the waiting area unless requested to do so else where by the caregiver while children are appropriately supervised. Observations are permitted if in the best interest for patient care and if following patient privacy laws. Please know that we are not permitted to answer questions about other patients or treatment procedures for other patients or disclose personal information about other clients. Likewise, please avoid personal discussions with other caregivers regarding patients while in the waiting room area. This is for the comfort and privacy of everyone.

- _____

Signature of legal representative of child Date

ACKNOWLEDGEMENT OF PRIVACY PRACTICES: I acknowledge that Language & Movement will use and disclose my personal health information for treatment, payment, and other healthcare operations and as otherwise permitted by law. I understand that I may request a copy of the Notice of Privacy Practices to provide further detailed information about how we use and/or disclose protected medical information about your child for treatment, payment, healthcare operations, and as otherwise allowed by law.

- _____

Signature of legal representative of child Date

CONSENT FOR PARENT OBSERVATION: I understand that other parents may observe my child in therapy as the parents observe their child in therapy. (initial the one that applies)

- _____ I consent to the presence of other parents in the same treatment area with my child as the parents observe their child in therapy.
- _____ I do not consent to have other parents in the same treatment area as my child.

PHOTOGRAPH RELEASE: I hereby authorize Language & Movement to photograph and/or video-tape my child for the purposes of treatment, education, and professional reasons. (initial the one that applies)

- _____ I consent to my child being photographed and/or video-taped.
- _____ I do not consent to my child being photographed and/or video-taped.

Financial Responsibility

- ✓ **All parents are expected to know and understand their coverage and benefits for therapy services.**

Although we will verify insurance benefits prior to your first appointment, you may also check your benefits by calling the phone number on your insurance card and speaking with a representative from the insurance company. It is very important that you ask specifically about any "exclusions" or "limitations" to therapy benefits. **A quote of benefits from your insurance company is not a guarantee of payment.**

- ✓ In the event your insurance chooses not to pay for services, you are ultimately responsible for all charges.
- ✓ Please provide Language & Movement with a copy of your insurance card each time you receive a new card and/or your insurance information changes.
- ✓ Please understand that if your insurance company delays payment or is waiting on additional information before they render payment, and the balance due is **past 60 days, the balance is your responsibility and is due immediately. At this time, if payment is not made immediately, services will be placed on hold until the balance is paid in full.**
- ✓ If we are not filing insurance for you, payment for services is due at the time of service.
- ✓ We will do our best to answer any insurance related questions. However, calling your insurance company directly is frequently required.
- ✓ Any follow-up regarding non-payment after our initial appeals process is your responsibility.
- ✓ **Co-payments are to be paid at the time of service.**
- ✓ **Any portion of the therapy fees not reimbursed by your insurance company is your responsibility**.
- ✓ You are responsible for payment of any no-show cancellations.

FINANCIAL RESPONSIBILITY

I have read the above and hereby accept all responsibility for the evaluation and treatment costs incurred by my child. The undersigned certifies that he/she has been provided the evaluation and treatment costs and is the responsible party and accepts these terms.

Responsible Party's Signature: _____ Date: _____

INSURANCE INFORMATION

Name of insurance company:_____ Insurance Co. Address:_____

Subscriber Name:_____ Patient Id # _____Group #_____

Subscriber's Social Security #:_____Subscribers DOB: _____

Relationship to patient:_____ Subscriber's Employer's Name:_____

I authorize Language & Movement to keep my signature on file and to charge my account for copays and/or balance of charges not paid by insurance within 60 days and not to exceed $_____ .

Circle One: Visa Master Card Discover

☐This visit only ☐All visits this year ☐Co-Payments ☐No show or late cancellation charges ☐All of the above

Cardholder's Name: _____ Cardholder's Signature: _____

Account Number: _____ Expiration Date: _____

3-digit Security Code: _____

Release of Liability

Date:_____

I,_____ hereby release Language & Movement, Inc. from any and all liability resulting in any possible injury caused by toys given to my son/daughter,_____, as part of their patient incentives.

_____ _____

Signature Date

I, _____, legal guardian of_____ understand that there are inherent risks involved with a patient's participation in therapeutic activities at Language & Movement, Inc.

The use of equipment such as trampolines, swings, scooter boards, slides, utensils, balls and unstable surfaces among many other unlisted equipment & therapeutic toys may be used during therapy sessions.

Although, the staff at Language & Movement, Inc. prioritizes safety with all treatment sessions, I understand that there is potential for injury while participating in activities at Language & Movement, Inc.

I,_____ for myself, and on behalf of my heirs, assigns, personal representative, & next of kin, hereby release and hold harmless Language & Movement, Inc., it's directors, officers, agents, contract workers, volunteers, employees, and other participants of, and from any and all claims, demands, lawsuits, expenses, damages, and liabilities of every kind and nature whether known or unknown with respect to any injury, disability, death, or loss or damage to person or property in connection to participation in activities affiliated with Language & Movement, Inc. to the fullest extent of the law.

_____ _____

Signature Date

LANGUAGE & MOVEMENT GENERAL POLICIES

The following information is a list of general guidelines that will help create a treatment environment that is as efficient and smooth as possible. If you have any questions, please speak with your therapist.

1. Please have your child dressed in comfortable clothing that may get dirty during therapy.

2. If you want to observe the treatment session, please discuss this with your therapist **first.** Due to the **HIPAA privacy laws** there are specific procedures that must be followed to ensure the privacy of other clients in our therapeutic setting.

3. We expect patients to be on time for appointments. It is strongly recommended that a patient be here no earlier than 10 minutes prior to the start of therapy to prevent disorganization of the child in waiting. If you arrive early, your child's appointment will not start until their designated appointment time. Please wait with your child in the waiting room for your therapist, **no roaming** in the clinic, please. This is for the **safety of everyone.**

4. It is the caregiver's privilege to "drop off" a child but they must **never be unattended in waiting**. The caregiver who picks up you child must be here at least 15 minutes prior to the end of the therapy session. If you are late picking your child up or are unable to leave a cell number, you will be asked not to leave the facility.

5. The last few minutes of your child's session will be used to discuss your child's progress in therapy and review any home activities the therapist recommends. Please keep in mind our therapists have very busy schedules and be respectful of their time by bringing your discussions to an end by the top of the hour. If you have additional questions or would like to discuss your child's progress further, please email or call the therapist. If you feel you need a significant amount of time to talk to your child's therapist, you may schedule a consultation appointment with your therapist. The charge for this appointment is $40.00/30 minutes. This fee is due from you at the time of the appointment and will not be billed to insurance. This appointment is also subject to our cancellation policy.

6. If you are running late for an appointment, please call and let your therapist know. It may be possible to extend your time, depending on scheduling.

7. If your child has had a **fever within 24 hours of an appointment**, please cancel the appointment promptly. Also, **do not bring ill siblings into the waiting area**. We see many children throughout the day in the clinic and would like to ensure that everyone stays healthy.

ATTENDANCE / CANCELLATION POLICY

• If you must cancel an appointment, please do so by giving **24 hours notice**. We do encourage rescheduling your appointment if possible. It is essential to keep a regular schedule for any treatment to be successful. Understanding that emergencies do occur, it is our policy that any **cancellation with less than 3 hours notice** will result in a charge of **$25.00**. These charges are not reimbursable by your insurance company and must be paid at the time of your next scheduled therapy appointment.

• If you do not show up or **"NO-SHOW"** for your appointment and do not give notice, you will be charged the rate of **$50.00**. These charges are not reimbursable by your insurance company and must be paid at the time of your next scheduled therapy appointment.

• **Three "no show " cancellations**, missing more than **50%** of the scheduled treatment sessions, or habitual cancellations will result in the loss of a reserved treatment time slot and/or your child being **discharged from therapy.**

• You will be notified as far in advance as possible when your therapist is ill, on vacation or attending a continuing education conference. Every effort will be made to reschedule your appointments so that your child will miss as little treatment as possible.