Walker's Tiny Talkers

Pediatric Therapy Services

New Patient Intake Form

Identifying and Family Information:

Child's Name:_____ Birthdate:_____ Sex: ❑ M ❑ F

Caregiver 1: _____ Daytime Phone:_____

Address:_____ Cell Phone:_____

_____ E-mail:_____

_____

Caregiver 2: _____ Daytime Phone:_____

Address:_____ Cell Phone:_____

_____ E-mail:_____

_____

Doctor's Name: _____ Doctor's Phone: _____

Child lives with (check one):

❑ Birth Parents ❑ Foster Parents ❑ One Parent

❑ Adoptive Parents ❑ Parent and Step-Parent ❑ Other _____

Other children in the family:

Name	Age	Sex	Grade	Speech/Hearing Problems

Child's race/ethnic group:

❑ Caucasian, Non-Hispanic ❑ Hispanic ❑ African-American

❑ Native American ❑ Asian or Pacific Islander ❑ Other _____

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

If yes, which one?_____

Does the child speak the language? ❑ Yes ❑ No

Does the child understand the language? ❑ Yes ❑ No

Who speaks the language? _____

Which language does the child prefer to speak at home? _____

Speech-Language-Hearing

Do you feel your child has a speech problem? ❑ Yes ❑ No

If yes, please describe. _____

_____

_____

Do you feel your child has a hearing problem? ❑ Yes ❑ No

If yes, please describe. _____

_____

_____

Has he/she ever had a speech evaluation/screening? ❑ Yes ❑ No

If yes, where and when? _____

What were you told? _____

_____

_____

Has he/she ever had a hearing evaluation/screening? ❑ Yes ❑ No

If yes, where and when? _____

What were you told? _____

_____

_____

Has your child ever had speech therapy? ❑ Yes ❑ No

If yes, where and when? _____

What was he/she working on? _____

_____

Has your child received any other evaluation or therapy (physical therapy, counseling, occupational therapy, vision, etc.)? ❑ Yes ❑ No

If yes, please describe._____

_____

_____

_____

Is your child aware of, or frustrated by, any speech/language difficulties?_____

_____

What do you see as your child's most difficult problem in the home? _____

_____

What do you see as your child's most difficult problem in school?_____

_____

Birth History

Was there anything unusual about the pregnancy or birth? ❑ Yes ❑ No

If yes, please describe. _____

_____

_____

How old was the mother when the child was born? _____

Was the mother sick during the pregnancy? ❑ Yes ❑ No

If yes, please describe. _____

_____

How many months was the pregnancy?_____

Did the child go home with his/her mother from the hospital? ❑ Yes ❑ No

If child stayed at the hospital, please describe why and how long. _____

_____

_____

Medical History

Has your child had any of the following?

- ❑ adenoidectomy
- ❑ allergies
- ❑ breathing difficulties
- ❑ chicken pox
- ❑ colds
- ❑ ear infections
  How often?_____
- ❑ ear tubes
- ❑ encephalitis
- ❑ flu
- ❑ head injury
- ❑ high fevers
- ❑ measles
- ❑ meningitis
- ❑ mumps
- ❑ scarlet fever
- ❑ seizures
- ❑ sinusitis
- ❑ sleeping difficulties
- ❑ thumb/finger sucking habit
- ❑ tonsillectomy
- ❑ tonsillitis
- ❑ vision problems

Other serious injury/surgery: _____

Is your child currently (or recently) under a physician's care? ❑ Yes ❑ No

If yes, why?_____

_____

Please list any medications your child takes regularly: _____

_____

_____

Developmental History

Please tell the approximate age your child achieved the following developmental milestones:

_____ sat alone
_____ babbled
_____ put two words together
_____ walked
_____ grasped crayon/pencil
_____ said first words
_____ spoke in short sentences
_____ toilet trained

Does your child...

- ❑ choke on food or liquids?
- ❑ currently put toys/objects in his/her mouth?
- ❑ brush his/her teeth and/or allow brushing?

Current Speech-Language-Hearing

Does your child...

- ❑ repeat sounds, words or phrases over and over?
- ❑ understand what you are saying?
- ❑ retrieve/point to common objects upon request (ball, cup, shoe)?
- ❑ follow simple directions ("Shut the door" or "Get your shoes")?
- ❑ respond correctly to yes/no questions?
- ❑ respond correctly to who/what/where/when/why questions?

Your child currently communicates using...

- ❑ body language.
- ❑ sounds (vowels, grunting).
- ❑ words (shoe, doggy, up).
- ❑ 2 to 4 word sentences.
- ❑ sentences longer than four words.
- ❑ other _____.

Behavioral Characteristics:

- ❑ cooperative
- ❑ attentive
- ❑ willing to try new activities
- ❑ plays alone for reasonable length of time
- ❑ separation difficulties
- ❑ easily frustrated/impulsive
- ❑ stubborn
- ❑ restless
- ❑ poor eye contact
- ❑ easily distracted/short attention
- ❑ destructive/aggressive
- ❑ withdrawn
- ❑ inappropriate behavior
- ❑ self-abusive behavior

School History

If your child is in school, please answer the following:

Name of school and grade in school: _____

_____

Teacher's name: _____

_____

Has your child repeated a grade? _____

_____

What are your child's strengths and/or best subjects? _____

_____

Is your child having difficulty with any subjects? _____

_____

Is your child receiving help in any subjects? _____

_____

Additional Comments

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Walker's Tiny Talkers LLC 1450 SE J St, Suite 4 Bentonville, AR 72712
Please Fax (479) 439-6898 or email to rwalker@walkerstinytalkers.com

Walker's Tiny Talkers

Pediatric Therapy Services

Confidentiality and HIPAA Disclosure

This form describes the federal confidentiality laws outlined by the Health Insurance Portability and Accountability Act (HIPAA). All information shared between you and Walker's Tiny Talkers LLC during intake, evaluation, treatment, and counseling sessions will be held in strict confidentiality according to federal regulations. Federal law dictates that a copy of this information is provided to all clients before the initiation of evaluation or therapy services.

Definitions:

a. *Protected Health Information (PHI)* refers to any information in your health file that may identify you, such as your name, address, diagnoses, and medical and/or treatment history.

b. *Treatment* refers to time spent with you in treatment, evaluation, and consultation to discuss questions and concerns. This also includes time spent managing your treatment and other services related to your healthcare, including consulting with another healthcare provider such as your general practitioner (GP) or another speech pathologist. [OR RELEVANT SERVICE PROVIDER]

c. *Payment* refers to filing for reimbursement for your therapy services, such as when PHI must be disclosed to insurance companies to obtain payment or determine eligibility or coverage. Requested documents may include diagnostic codes and reports, types of therapy services provided, times and dates of

sessions, therapy progress, description of impairment, case notes, and summarizations.

d. *Health Care Operations* refer to activities related to the performance and operation of Walker's Tiny Talkers LLC, such as quality assurance and improvement, audits, administrative services, accounting, case management, and coordination of care.

e. *Use* applies only to activities within the private practice of Walker's Tiny Talkers LLC such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you or your PHI.

f. *Disclosure* applies to activities outside of the private practice office of Walker's Tiny Talkers LLC such as releasing, transferring, or providing access to information about you to other parties.

g. *Authorization* is your written permission to disclose confidential health information. All authorizations to disclose must be signed for on a specific, legally required form.

Uses and Disclosures with Authorization for Treatment, Payment, and Healthcare Operations

Protected Health Information (PHI) may be used or disclosed for treatment, payment, and healthcare operation purposes as defined above given your written authorization. You may revoke all such authorizations at any time, provided that each revocation is in writing. Revocation will not apply to a) authorizations already acted upon, b) authorizations obtained as a condition of obtaining insurance, disability, or worker's compensation coverage, c) a court ordered or third-party referral in which you are not legally defined as the client.

Uses and Disclosures without Authorization

Protected Health Information (PHI) or client information may be used or disclosed without your written consent only in the following circumstances:

a. *Mandated reporting of child abuse*: In the event that Walker's Tiny Talkers LLC has reasonable cause to believe a minor or elder may be abused or neglected, there is an obligation to report this belief to the appropriate legal authorities.

b. *Mandated reporting of adult and domestic abuse*: In the event that Walker's Tiny Talkers LLC has reasonable cause to believe an individual protected by state law has been abused, neglected, or financially exploited, there is an obligation to report this belief to the appropriate legal authorities.

c. *Serious threat to health or safety*: In the event that Walker's Tiny Talkers LLC learns through client interaction or records that there is a specific threat of imminent harm, or risk of physical or mental injury against yourself or another individual, the company is obligated to disclose this information to protect yourself and/or others from harm.

d. *Oversight agencies*: Reporting of PHI to oversight agencies for activities authorized by law, including licensure, certification, and disciplinary actions is required.

e. *Court and judicial proceedings*: If you are involved in a court proceeding and requests for records of your diagnostic or treatment records are made, this information is privileged under state law and must not be released without a court order. This privilege does not apply if you are being evaluated by a third party or where the evaluation is court ordered. You must be informed in advance in this case. PHI may also be released directly to you upon request.

f. *Worker's compensation*: In the event of a worker's compensation claim in which speech pathology evaluation and treatment is relevant, PHI may be disclosed as authorized by and to the extent necessary to comply with laws relating to worker's compensation and other similar programs established by law that provide benefits for work-related injuries or illness without regard to fault.

g. *Professional consultation*: Walker's Tiny Talkers LLC may consult with other professionals in order to aid client treatment and progress without written authorization only if information discussed does not reveal any identifying information covered under PHI.

h. *Minors and guardianship*: Parents and legal guardians of non-emancipated minor clients have the right to access the client's records and discuss evaluation and treatment with Walker's Tiny Talkers LLC.

Patient Rights

a. *Right to request restrictions*: You have the right to request restrictions on certain uses and disclosures of PHI, but Walker's Tiny Talkers LLC is not obligated to honor this request.

b. *Right to receive confidential communication by alternative means or at alternative locations*: You have the right to request and receive confidential documentation and communications of PHI by alternative means or alternative locations. For example, you may request to have your documentation sent to a separate address for additional privacy.

c. *Right to inspect and copy***:** You have the right to inspect and/or obtain a copy of your PHI collected by Walker's Tiny Talkers LLC for as long as these records are maintained by the company.

d. *Right to amend:* You have the right to request an amendment of your PHI collected by Walker's Tiny Talkers LLC for as long as these records are maintained by the company.

e. *Right to an accounting:* You have the right to receive an accounting of all disclosures of PHI.

f. *Right to a paper copy:* Documents may be exchanged between you and Walker's Tiny Talkers LLC electronically. Walker's Tiny Talkers LLC will make every reasonable attempt to keep this information protected, including password protection of electronic documents and secured webpages. However, information transmitted via email or fax may not be encrypted. You may request to obtain paper copies of documentations or alternative means of contact such as mail or telephone, instead of electronic communications.

Company/Therapist Duties

a. Walker's Tiny Talkers LLC and its contractors, employees, and directors are required by law to maintain the privacy of PHI and to provide clients with a notice of its legal duties and privacy practices with respect to HIPAA and PHI.

b. Walker's Tiny Talkers LLC reserves the right to change privacy policies and practices as described in this notice but is bound to abide by the terms in effect until you are notified of any changes.

Complaints

If you are concerned that Walker's Tiny Talkers LLC has violated your privacy rights or disagree with a decision made by Walker's Tiny Talkers LLC about your records, please contact the company in writing at 1450 SE J Street Suite 4, Bentonville, AR 72712.

The law also provides that you may send a written complaint to the Secretary of the U.S. Department of Health and Human Services (DHS). This address will be provided to you by Walker's Tiny Talkers LLC upon request.

Effective Dates of Privacy Policies

This notice will go into effect on 07/25/2000.

Walker's Tiny Talkers LLC agrees to limit the uses and disclosures of confidential client information as defined by Arkansas Law and the ethical recommendations put forth by the American Speech-Language-Hearing Association (ASHA).

Walker's Tiny Talkers LLC reserves the rights to change the terms of this notice and make new policies effective for all PHI information maintained. In the event of a policy change to client confidentiality, the company will provide you with a revised notice in person or via mail if requested by you in writing.

By signing below, I acknowledge that I have been provided with a copy of Walker Tiny Talker's confidentiality policies as outlined by federal, state, and local regulations including Arkansas state law and HIPAA. I have read, or have had read to me, this document in its entirety. I acknowledge and agree to the outlined policies on client confidentiality and understand their meanings and ramifications.

Printed Name: _____

Signature: _____

Date: _____

Walker's Tiny Talkers

Pediatric Therapy Services

Consent to Release/Request Confidential Information

Patient Information

Full Name: Date of Birth:

Consenting Adult/Guardian Information

Full Name:

Relationship to Patient:

☐ Self ☐ Parent ☐ Legal Guardian ☐ Foster Parent

☐ Adult Caregiver ☐ Other (please explain):

Phone Number: ( ) _____-_____

Email Address: _____

I, _____, hereby request and authorize Walker's Tiny Talkers LLC to communicate with and exchange information, if necessary, regarding personal, educational, medical, and/or therapeutic evaluation and treatment information concerning services provided for

_____ (patient names).

Walker’s Tiny Talkers LLC

www.walkerstinytalkers.com • support@walkerstinytalkers.com • (479)439-6898

Specialist, Agency, or Institution Information

Organization Name:

_____

Doctor/Contact Name and Specialty:

_____

Address:

_____

City: _____ **State**: _____ **Zip Code**: _____

Phone Number: ( ) _____-_____ **Email Address**: _____

I acknowledge by signing below that confidential patient information will be exchanged between Walker’s Tiny Talkers LLC and the listed parties in order to coordinate communication and continuity of care for the patient. Above permission includes, but is not limited to, oral communication, summaries of treatment, copies of records and diagnoses, as necessary. Confidential patient information will not be released to any other individuals or organizations except the patient’s legal guardian or coordinator of care unless specified in writing or in the event of mandated reporting. This permission is granted for one (1) calendar year. I understand that I have the

right to inspect and copy all information to be disclosed. I further understand that my consent is voluntary and can be revoked at any time.

Printed Name: _____ **Date**: _____

Signature: _____

If signing on behalf of patient, please list their full name(s) here:

_____

_____

_____

----------OFFICE USE ONLY----------

Staff Signature: _____

Date request of release obtained: _____ Date copies and records provided: _____

Walker's Tiny Talkers

Pediatric Therapy Services

Service Provision Agreement

This Service Provision Agreement, dated _____, is made between Walker's Tiny Talkers, a Arkansas, LLC company (the "Company") with its principal office located at 1450 SE J St Suite 4 Bentonville, AR 72712 and _____ (the "Client"). Hereafter, Client refers to any individual over the age of 18 able and willing to voluntarily enroll in a therapeutic program or, in the event of services provided to a minor, a legal parent or guardian serving as the primary contact and provider of payment for all services rendered. By signing this agreement, the Client agrees to the mutual terms and conditions outlined as follows:

Disclaimer: Client acknowledges that the Company cannot provide guarantees of therapy results including, but not limited to, treatment outcomes, effectiveness of procedures, or number of treatment sessions required. Client also acknowledges that therapy outcomes are dependent on a variety of factors including regular attendance, completion of any homework or additional practice activities outside therapy, and patient motivation. The Company will discuss treatment progress with Client and schedule additional consultative meetings with Client as needed. The Company reserves the right to refuse or discontinue services if unable to provide quality, ethical services to Client. If further evaluation or treatment in indicated in another area of therapy or service, The Company will attempt to provide Client with a referral for an appropriate service provider.

Confidentiality: All information shared between Client and the Company during intake, evaluation, treatment, and counseling sessions will be held in strict confidentiality

according to federal regulations. Release of confidential Client information to other individuals, agencies, or professionals may only be done with written consent of Client. The following exceptions to patient confidentiality are acknowledged: 1) mandated reporting, such as reporting of child or elder abuse, 2) court or administrative subpoena, 3) suspected personal danger to Client or an identifiable victim, 4) information required by insurance company for reimbursement or by employer for worker's compensation claim, 5) information provided to legal parents or guardians of minors, 6) valid collection of debt, 7) consultation with other professionals in order to aid treatment without revealing identifying information unless written consent is obtained. Client acknowledges that any information transmitted via email between Client and the Company may not be encrypted. Client may request in writing that the Company provide alternative means of contact, such as mail or telephone, to ensure confidential communication. Please refer to the provided HIPAA disclosure for more information regarding Protected Health Information (PHI) and client confidentiality.

Termination: This agreement shall be in effect from the date first written above until terminated by either Client or Company. Client has the right to withdraw consent for any further evaluation, treatment, or counseling services at any time. The Company requests that Client discuss questions and concerns prior to termination to allow for potential changes to treatment plan or recommendations for alternative service providers to be provided as appropriate. The Company accepts responsibility to discuss treatment progress with Client and schedule additional consultative meetings as needed.

The Company reserves the right to transfer clients between therapists contracted or employed by the Company as needed or appropriate to ensure continuity of care but will notify Client in advance of any such transfer.

Insurance: The Company will file with in network insurance providers. It is the Client's responsibility to ensure that they are in network and have valid insurance for the therapy rendered. Client hereby accepts personal responsibility for all payment. Client accepts all responsibility for completing and filing any necessary paperwork required for reimbursement of out of network benefits, if eligible. The Company will provide Client with a receipt for services provided, evaluation and therapy reports, and treatment plans if Company is given 48 hours' advance notice. Initial evaluation reports will be provided to Client as a part of the fee for assessment.

Payment: Payment for initial evaluation is due at the time of service. Client will be billed monthly for provided therapy and counseling services including any cancelation fees, administrative fees, and additional services such as meeting attendance or phone conferences. Payment is required in full within 10 business days of receipt of bill. Failure to pay bill in a timely manner may result in discontinuation of services, additional late

payment fees, legal action, and/or submission of Client information to collection agency. Payment is accepted in the form of cash, personal checks, and major credit cards. Please make checks payable to Walker's Tiny Talkers. **Initial:_____**

Cancellations and Late Arrivals: The Company acknowledges that circumstances such as emergencies, illness, and schedule changes may prevent Client from participating meaningfully in therapy activities. However, the Company has enacted the following cancellation policy to ensure that therapy times are available to all clients and that our therapists can schedule their valuable time accordingly.

Client will be allowed **five (5)** session cancellations at no charge per calendar year provided that at least 24 hours' notice is given for each cancellation. Client will be charged 50% of the session rate for any additional cancellations within calendar year unless mutual written agreement has been reached with the Company to discontinue or temporarily suspend therapy services. Any sessions canceled with less than 24 hours' advanced notice (including "no shows") will be charged the **full amount** for the missed session.

The Company reserves the right to reschedule services at any time due to Client illness, noncompliance, or safety concerns. Additionally, the Company reserves the right to reschedule or shorten any appointments due to late arrival by Client. These sessions may be counted against the five (5) cancellations provided at no charge at the sole discretion of the Company.

- Sessions rescheduled by the therapist due to Client illness, noncompliance, or safety concerns will be billed only for the time in attendance (e.g., if the therapist arrives and Client is unable or unwilling to participate in therapy activities, the session may be discontinued for the day).
- Sessions shortened due to late Client arrival (i.e., 45 minute session instead of 60 minute session) will be billed for the full session.
- Any cancellations (including those *with* 24 hours' notice) past the five (5) provided cancellations will be billed for 50% of the full session rate.
- Any late cancellations *with less* than 24 hours' notice will be billed for the full session.

The Company will provide Client with 24 hours' advance notice for any cancellations due to therapist absence or schedule changes. These cancellations will not count toward the **five (5)** cancellations provided at no charge to the Client, and Client will not be charged for any missed sessions due to therapist absence.

Notification of cancelations must be sent to Company by email at support@walkerstinytalkers.com or by phone or text at (479) 439-6898.
Initial:_____

Online Services: If using online teletherapy, please be advised of the following requirements for adequate technology specifications and therapy environment.

- Please arrive to your online therapy room on time. If you have difficulty logging on, contact your therapist immediately for assistance. Sessions that start late will not be given additional time unless at the discretion of the Company.
- Provide a distraction free background for adequate focus to therapy tasks. This includes a quiet room with a closed door away from noise and distractions such as other people in the house, TVs, animals, etc.
- Place your computer so that light is focused on your face without backlighting. You may need to use a small desk lamp rather than window lighting or an overhead light for the best focus on your face.
- Please have an adult log-in all children to therapy and stay present in the home for the duration of the session in the event of behavioral difficulties or technological troubleshooting. Some children may require adults to stay in the room and participate in therapy more directly at the discretion of the therapist.
- Hardware and software
    - Either a laptop or standalone Mac or PC
        - **Chromebooks, tablets, iPads, and phones are not adequate**
        - If PC, updated to Windows 7 or 10
        - If Mac, updated to Mac OS X 10.9 or 10.11
    - A high-speed Internet connection of at least 10 Mbps
        - Preferably wired with an Ethernet cable into the router/wall
    - A built-in or standalone webcam
    - A built-in or standalone (desktop) microphone with speakers or USB (preferred) microphone/speaker headset
    - One standalone monitor or built-in laptop screen
    - Standard keyboard and handheld mouse (laptop trackpad is not sufficient)

- A working telephone nearby

General Provisions: The sections of this Service Provision Agreement are severable, and the invalidity of any one or more section(s) shall not affect or limit the enforceability of the remaining sections. This Agreement constitutes the entire agreement between the Parties with respect to all of the matters discussed above, and its execution has not been induced by and is not reliant on any representations not stated in this Agreement. No amendment or modification of this Agreement shall be valid unless written in a document signed by both Parties. The Company's failure to exercise, or delay in exercising, any right, power, or privilege under this Agreement shall not operate as a waiver; nor shall any single or partial exercise of any right, power, or privilege preclude any other or further exercise thereof. Any claim, litigation, or dispute of any sort arising from this Agreement must first be presented to the other Party in a good faith effort to resolve the dispute. If resolution cannot be reached between the two Parties, the courts of Nassau County, Florida will have exclusive jurisdiction. This Agreement shall be governed by the laws of the [YOUR STATE] without regard to its choice of law rules.

If you have any questions regarding these policies, evaluation or therapy details, or other information, please contact the Company by email at support@walkerstinytalkers.com or by phone at (479)439-6898. We strive to maintain open, clear communication with our clients to build lasting relationships.

Signature page follows.

I, _____, acknowledge that I have been provided a copy of this service provision agreement and have read, or have had read to me, this document in its entirety. I agree to abide by the policies and procedures outlined in this agreement including payment and cancellation policies. I understand that Walker's Tiny Talkers has not provided a guarantee of any services, and that I maintain the right to withdraw my consent for additional services at any time. I understand that upon termination of treatment, Walker's Tiny Talkers withholds the right to deny further evaluation, treatment, or counseling.

□ I consent to a speech language pathology evaluation.

□ I consent to ongoing speech language pathology therapy (as appropriate).

Client Name: _____

Client Signature: _____

Or if Client is under 18 years of age or under legal guardianship:

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____

Company Name: Walker's Tiny Talkers

Signature of Company's Manager, Randi Walker, M.S. CCC-SLP : _____

Patient Intake Form

Please fill in all the information as accurately as possible. The information you provide will assist in formulating a complete health profile. All Answers are confidential.

PATIENT INFORMATION

First Name _____ Last Name _____ Date of Birth _____

Sex ____ Marital Status _____ Email Address _____

Address _____ City _____ State _____ Zip Code _____

Home Phone ( )_____ Cell Phone ( )_____ Work Phone ( )_____

EMERGENCY CONTACT

Name _____ Relationship _____

Home Phone ( )_____ Cell Phone ( )_____ Work Phone ( )_____

Name _____ Relationship _____

Home Phone ( )_____ Cell Phone ( )_____ Work Phone ( )_____

INSURANCE INFORMATION

Insurance Carrier _____ Insurance Plan _____

Contact Number _____ Policy Number _____

Group Number _____ Primary Care Physician _____