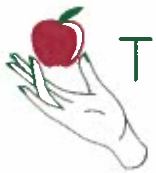

THE GIVING VOICE

Date:_____

Person completing form: _____ Relationship: _____

CHILD IDENTIFICATION

Name: _____ Birthdate: _____ Sex: M [ ] F [ ] Age: _____

Address:_____

Referred by:_____

Medical Diagnosis: _____ Age of Diagnosis: _____

Parent Name (s): _____

Address/different from above: _____

Phone: _____ [ ] Cell [ ] Home [ ] Work
_____ [ ] Cell [ ] Home [ ] Work

**** FOR OFFICE USE ONLY****

Date: _____ Name of Staff Conducting Interview: _____

Recommended follow-up: _____

19350 Belview Drive
Cutler Bay FL, 33157
(P): (305)-964-5767
(E): info@givingvoicetherapy.com

FAMILY

Siblings:

Name	Age	Sex	Grade	Speech/Hearing/Medical Problems

GENERAL DEVELOPMENT

Pregnancy and Birth History:

Which pregnancy was this child? _____ Length of pregnancy: _____

What illness, diseases, or accidents occurred during pregnancy? [ ] None

_____

Were there any problems at birth? [ ] None [ ] Yes

Please describe:

_____

Weight of child at birth: _____

Did the infant require oxygen? [ ] Yes [ ] No

Any abnormalities? [ ] Yes [ ] No

_____

Were there any problems during the first 2 weeks of the infant's life? (health, swallowing, sucking, feeding, etc.) [ ] Yes [ ] No

_____

_____

MEDICAL HISTORY

Is your child currently under the care of a doctor? [ ] Yes [ ] No. If yes, please describe:

_____

Is he/she taking medication? [ ] Yes [ ] No Type?_____
Why?_____

Describe any illness, injuries, operations, or physical problems

_____

_____

DEVELOPMENTAL MILESTONES

At what age did your child:

_____ sit up without support

_____ run

_____ drink from a cup

_____ first tooth

_____ crawl

_____ use words

_____ use spoon, fork, knife

_____ completely toilet trained

_____ walk

_____ speak sentences

_____ dress self

Hand Dominance: [ ] Right Handed [ ] Left Handed

BEHAVIOR

Please check mark all that apply:

- ☐ Eating Problems
- ☐ Laughs easily
- ☐ Difficulty concentrating
- ☐ Emotional
- ☐ Difficult to manage
- ☐ Gets along with adults
- ☐ Excitable
- ☐ Toilet training problems
- ☐ Sensitive
- ☐ Needed a lot of discipline
- ☐ Gets along with other children
- ☐ Overactive
- ☐ Sleeping problems
- ☐ Cried a lot
- ☐ Stays with an activity
- ☐ Happy
- ☐ Underactive
- ☐ Prefers to play alone

Does your child separate from parents without crying or fussing? [ ] Yes [ ] No. If No, please describe:

_____

Does your child have a behavior modification plan? Does he/she see a behavior specialist? [ ] Yes [ ] No. If yes, please describe:

_____

Name :_____

EDUCATIONAL HISTORY

School now attending: _____ Grade: _____

Address: _____

Does your child have an Individualized Education Plan (IEP)? Does your child attend a special education class? [ ] Yes [ ] No. If yes, please describe:

_____

Does your child have a dedicated educational assistant? [ ] Yes [ ] No

Subjects of interest/relative areas of strength: [ ] Yes [ ] No. If yes, please describe:

_____

_____

Difficult subjects:

_____

_____

What is your impression of your child's learning abilities?

_____

_____

_____

ATTENTION/SELF REGULATION

Does your child have a difficult time calming down to go to sleep or waking up in the morning? If so, please explain

Is your child irritable at predictable times of the day? If so, what events trigger this and when does it occur?

Does your child seem happier or more cooperative at predictable times of the day? Please describe

Does your child exhibit any impulsiveness, aggression, or immaturity more than other children his/her age? If so, please explain

Describe your child's ability to attend to activities (responding to his/her name or a question in a timely manner, table top tasks -vs-gross motor activity-vs-homework)

SELF CARE/DAILY ROUTINE

Please describe your child's eating habits (include # of meals, # of snacks, food likes/dislikes)

If your child is experiencing feeding problems, please provide additional information: foods you child eats regularly:

Foods your child used to eat but no longer eats:

Are there sensitivities to taste, explain:

Are there sensitivities to texture, explain:

Are there sensitivities to temperature, explain:

Are there concerns with your child's ability to bite, chew, move food around in the mouth, or swallowing, explain Please describe your child's sleep habits (include bedtime routine, # of hours, # of naps if any)

SPEECH/LANGUAGE

How does your child communicate? Circle those that apply:

- ☐ Spoken Words
- ☐ Augmentative system
- ☐ Gestures
- ☐ Physical guidance

If words were /are spoken please answer the following: When did he/she speak their first words?

_____

_____

What were the child's first few words?

_____

_____

When did they begin to use two-word sentences? Do they make sounds incorrectly?

_____

_____

How well are they understood? (By parent/caregivers, siblings, relatives, and strangers)

_____

_____

Do they hesitate, "get stuck," repeat, or stutter on sounds or words? Please describe:

_____

_____

Describe as completely as possible your concerns about the child's speech or language problem:

When did you first become concerned?

Have there been changes in the condition since you first noticed it?

What do you think caused this problem?

Does your child seem to be aware of the differences?

Are there any other languages spoken in the home? [ ] Yes [ ] No

Languages: _____

Has he/she had any therapy for speech or language? How has it helped?

Are there any family members or relatives who have had speech or language problems? Please specify:

Please check all that apply:

- ☐ Laughs less than normal
- ☐ Difficulty chewing
- ☐ Head banging and foot stamping
- ☐ Difficulty moving mouth
- ☐ Indifferent to sound
- ☐ Mouth breather
- ☐ Tongue-tied
- ☐ Large tongue
- ☐ Yells or screeches for attention
- ☐ Gags or chokes easily
- ☐ Uncoordinated
- ☐ Food came out nose
- ☐ Difficulty using tongue
- ☐ Talks through nose
- ☐ Cries less than normal
- ☐ Difficulty swallowing
- ☐ Temper tantrums
- ☐ Drooled a lot
- ☐ Difficulty breathing

Does not respond when spoken to? [ ] Yes [ ] No

How much did your child babble and coo during the first 6 months?

Did the development of your child's speech ever slow down or did he/she ever stop talking?

How does his/her voice sound?

- ☐ Normal
- ☐ Too High
- ☐ Too Low
- ☐ Hoarse
- ☐ Nasal
- ☐ Loud
- ☐ Soft

How well does your child understand what is said to them?

AUDIOLOGICAL HISTORY

Does your child have ear infections?

Does your child hear adequately? If no, please specify

When was your child's last hearing exam and what were the results

---

Child Information for Therapy Planning

Before we meet your child we would like to learn more about their interests and motivators, their sensory needs and their communication level. We are also interested to know if your child exhibits any behaviors that may impact his availability for learning. We use this information to help us plan for sessions and to develop behavior support protocols if necessary. Information is confidential.

1. What are your child's primary motivators/reinforcers?

---

2. What does your child show an aversion to (ex. reading tasks, paper pencil tasks etc)?

3.List 3-5 of your child's favorite activities, include toys, books, characters, topics, school subjects etc.

---

4. Does your child have any dietary restrictions? Please list your child's favorite snacks/drinks; please list only those that you would allow THE GIVING VOICE LLC. to give your child if snack is part of the session.

5. Does your child have any sensory needs or deficits; for example does he avoid or seek out certain textures, sounds or physical touch?

Needs/likes:

Aversions/dislikes:

7.Does your child have any behaviors that may impact his availability for learning (self -injurious behavior, aggression, eloping, verbal outbursts etc.) What typically causes these behaviors?

8. How does your child communicate his or her wants and needs?

THE GIVING VOICE

HIPAA NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and controls your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health

information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact with your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.

_____	_____	_____
Parent/Guardian Name (print please)	Parent/Guardian Signature	Date

THE GIVING VOICE
PATIENT RESPONSIBILITY FORM

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY:

I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service. Co-payments are due at time of service. If my plan requires a referral, I must obtain it prior to my visit.

In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided. If I am uninsured, I agree to pay for the medical services rendered to me at time of service. In the event that my scholarship or third party funding is unable to pay for medical services, I understand that I am financially responsible for the complete charge and agree to pay the costs of all services provided.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS:

I hereby authorize and direct payment of my medical benefits to, THE GIVING VOICE LLC., on my behalf for any services furnished to me by the providers.

I hereby authorize and direct payment of my scholarship/third party funding to, THE GIVING VOICE LLC., on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize, THE GIVING VOICE LLC., to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

4. MEDICARE REQUEST FOR PAYMENT

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in THE GIVING VOICE LLC. I authorize any holder of medical or other information about me to release to Medicare and its agents any

information needed to determine these benefits or benefits for related services.

Parent Name (Print Name Please)	Parent/Caregiver Signature	Date

I authorize the office of The Giving Voice LLC to use the following credit card to process payments and co-pays for services rendered to the client according to the Fee Agreement, Attendance Policy, and Insurance Agreement Forms. I understand that if an outstanding invoice is not paid, that I will be given a one week notification before my card will be charged.

Card #:_____

Expiration Date: _____ (Month/Year) CVV#: _____

Cardholder Name:_____

Credit Card Billing Address:_____

Street:_____

City:_____ State: _____ Zip: _____

Credit Card Type: __ Visa __ Mastercard__ Discover __ ApplePay

Email Address for Receipt: _____

THE GIVING VOICE

PRIVACY POLICY

I, _____ , have received a Notice of Privacy Practices for THE GIVING VOICE THERAPY LLC. to share my child's health information with:

Myself/Guardian: _____

My spouse: _____

Friends/Other Family member: _____

Therapist/Teacher: _____

_____	_____	_____
Parent/Guardian Name (print please)	Parent/Guardian Signature	Date

OFFICE USE ONLY:
We attempted to obtain written acknowledgement of receipt of our Privacy Policy, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other: _____

Phone: 305-964-5767
19350 Belview Drive, Cutler Bay, Fl 33157
Email: info@givingvoicetherapy.com

THE GIVING VOICE

ATTENDANCE POLICY

Thank you for choosing THE GIVING VOICE LLC for your therapy needs. We are committed to providing you with quality care. You and your therapist will work together to develop a plan that works best for you and your child. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

- If an appointment is not canceled at least 24 hours in advance you will be charged **50% of the missed therapy session**; *this will not be covered by your insurance company.*
- After 3 no shows (without any notification) you may be discharged from therapy. In the event you are discharged from therapy we will notify your physician of the reason for discharge.
- In order to maintain a safe environment, cancellations due to COVID require proof of two negative test results to continue therapy within the clinic.

I understand The GIVING VOICE LLC Attendance Policy. I will commit my time to the plan my therapist and I create together.

Parent/Guardian Name (print please) _____ Parent/Guardian Signature _____ Date _____

Phone: 305-964-5767
19350 Belview Drive, Cutler Bay, Fl 33157
Email: info@givingvoicetherapy.com

THE GIVING VOICE

MEDIA RELEASE FORM

I, _____ ,give THE GIVING VOICE THERAPY LLC. permission for my child, _____ to be photographed and/or videotaped at THE GIVING VOICE THERAPY LLC. Photographs and videos may be shared with the following (check those that apply):

- ☐ Physical, Occupational, Speech Therapists for training, evaluations, and treatment purposes.
- ☐ Presentations in the community regarding THE GIVING VOICE THERAPY LLC. and therapy.
- ☐ Givingvoicetherapy.com website when accompanied by my written pre-approval for specific video/pictures.
- ☐ Other staff and specialists working with my child (i.e. Teachers, therapists, doctors) for which I have signed an authorization for release.

I hereby hold harmless and agree to release and forever discharge The GIVING VOICE THERAPY LLC. from any and all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or nay other person acting on behalf of myself or on behalf of my estate have by reason of authorization. I have authorization to make the above decisions and represent any family members/guardians involved.

_____	_____	_____
Parent/Guardian Name (print please)	Parent/Guardian Signature	Date

☐ I do not want my child photographed, videotaped, or recorded.

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Email: info@givingvoicetherapy.com