3943 Dahlwiny Court • Atlanta, GA • 30350 • (404) 436-1311 • jen@reingoldspeechtherapy.com

Patient Intake Form

(PLEASE PRINT)

<table>
<tr><th colspan="6">Patient Information</th></tr>
<tr><td colspan="6">Date:</td></tr>
<tr><td>Child Last Name:</td><td>Child First Name:</td><td>Child Middle Name:</td><td>Date of Birth:</td><td>Age:</td><td>Sex:</td></tr>
<tr><td colspan="6">Parent/Guardian Name:</td></tr>
<tr><td colspan="3">Address:</td><td colspan="3">City, State, Zip Code:</td></tr>
<tr><td>Home Phone:</td><td>Mobile Phone:</td><td colspan="4">Email:</td></tr>
<tr><td colspan="6">Physician’s Name:</td></tr>
<tr><td colspan="6">Physician’s Address:</td></tr>
<tr><td colspan="3">Physician’s Phone:</td><td colspan="3">Physician’s Fax:</td></tr>
<tr><td colspan="6">Specialist:</td></tr>
<tr><td colspan="6">School Name and Grade:</td></tr>
<tr><td colspan="6">Referred By:</td></tr>
</table>

3943 Dahlwiny Court • Atlanta, GA • 30350 • (404) 436-1311 • jen@reingoldspeechtherapy.com

Parent Questionnaire

Date:	Name of child:	Preferred Name:

Date of birth:	Age:	Gender:

Mother's Name:	Occupation:
Father's Name:	Occupation:

Address:

Home Number:	Work Number:	Cell Number:

Mother's Email:	Father's Email:
Referred by:	Phone Number:
Person Completing this form:	Relationship:
Emergency Contact:	Phone Number:

Siblings

Name:	Age:	Gender:	Grade:
Name:	Age:	Gender:	Grade:
Name:	Age:	Gender:	Grade:

Does Anyone else in the family have speech, language, or hearing problems? ☐ Yes ☐ No
If yes, please describe:

What language does your child speak?

3943 Dahlwiny Court • Atlanta, GA • 30350 • (404) 436-1311 • jen@reingoldspeechtherapy.com

Educational/Social History

Name of school:	Type of program:	Name of teacher:
Has your child repeated a grade? ☐Yes ☐No If yes, what grade?		
Does your child receive assistance and/or special education services at school? ☐EIP ☐Tutoring ☐IEP ☐504 ☐Speech Therapy ☐Occupational Therapy ☐ Physical Therapy		
How does your child interact with other children/siblings?		
What are your child's favorite activities, toys, and interests?		
What things does your child do particularly well?		
List your child's easiest and most difficult subjects/areas:		
What does your child have trouble doing?		

Speech/Language History

Has your child ever had a speech 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, counseling, occupational, vision, etc)? ☐ Yes ☐No If yes, please describe:

3943 Dahlwiny Court • Atlanta, GA • 30350 • (404) 436-1311 • jen@reingoldspeechtherapy.com

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?
How does your child communicate? ☐Eye Contact ☐Gestures ☐Vocalizations ☐Jargon ☐Sign Language ☐PECS symbols ☐AAC device ☐Words ☐Phrases ☐Sentences ☐Conversations ☐Writing
What efforts does your child make to communicate his/her wants and needs when not understood?
Is your child's speech understandable to you ☐Yes ☐No? To family ☐Yes ☐No? To Friends ☐Yes ☐No? To strangers ☐Yes ☐No?
Does your child's speech ever seem to stop or slow down for a period of time? ☐Yes ☐No If yes, please describe:
Can your child follow directions? ☐Yes ☐No ☐Step 1 ☐Step 2 ☐Multi-step
How is your child's attention span?
What have you done to help your child's speech and language?
Birth/Medical History
Is your child adopted? ☐Yes ☐No At what age? From what country?
Please list any complications or illnesses that occurred during pregnancy (i.e. toxemia, CMV, etc.)
Were any medications taken during pregnancy? If yes, please list:
Weight at birth? Was he/she full-term? ☐Yes ☐No
Please briefly describe your child's medical history including allergies:

3943 Dahlwiny Court • Atlanta, GA • 30350 • (404) 436-1311 • jen@reingoldspeechtherapy.com

Please list any medications your child takes regularly:
Has your child ever been examined by any other professionals (neurologists, OT, PT, etc.) ☐Yes ☐No If yes, please describe and provide a copy of the evaluation:
What is and has been your child's general medical condition?
Please list any health conditions, surgeries, etc.:
Has your child had his/her tonsils and adenoids removed? ☐Yes ☐No
Has your child had any ear trouble (earaches, infections)? ☐Yes ☐No How Many?
Has your child's hearing ever been tested? ☐Yes ☐No If yes, date of testing Results of hearing test
Has your child ever had (PE) tubes inserted? ☐Yes ☐No If yes, when?
Has your child ever worn glasses ☐Yes ☐No
Does your child have dental problems? ☐Yes ☐No
Has your child had any seizures? ☐Yes ☐No If so, are these treated with medications? ☐Yes ☐No
Does your child have any known skin allergies ☐Yes ☐No To Latex ☐Yes ☐No
Does your child have any food allergies or is he/she on a restricted diet? If so, please explain:

Developmental History

Were developmental milestones met on time? ☐Yes ☐No If not, please describe:	
Indicate the age at which your child: (Please write "NA" if not applicable)	
Began to babble	Had a vocabulary of 50 words
Said first words	Began to say two-word sentences
What were they?	Began to say three-word sentences
Began asking questions	Sat up
Crawled	Walked

3943 Dahlwiny Court • Atlanta, GA • 30350 • (404) 436-1311 • jen@reingoldspeechtherapy.com

Does your child show aversive reaction to touching certain objects or textures? ☐Yes ☐No

☐On Hands ☐On Feet ☐On Mouth/Lips ☐On body ☐On Face ☐Inside Mouth

Feeding

Did your child have any feeding problems in early life? ☐Yes ☐No. If yes, please describe

Are there any presents eating problems? ☐Yes ☐No If yes, please describe

Does your child have difficulty chewing and swallowing? ☐Yes ☐No

Does your child drool? ☐Yes ☐No

Is your child a picky eater? ☐Yes ☐No

What are your child's favorite foods?

Is there anything your child refuses to eat?

Does your child use utensils? ☐Yes ☐No

How does your child take in liquid?
☐Syringe ☐Bottle ☐Nubby Cup ☐Sippy Cup ☐Straw ☐Cup

Other

Please provide any additional information that you think is important/relevant about your child's medical, social/emotional, and academic history:

3943 Dahlwiny Court • Atlanta, GA • 30350 • (404) 436-1311 • jen@reingoldspeechtherapy.com

HIPAA PRIVACY PRACTICES

Overview

The purpose of this document is to ensure that you are aware of your rights to ensure the privacy of your child's healthcare information. Reingold Speech Therapy retains the right to update this notice at any time. You may specify your designated contacts. This document outlines how protect health information (PHI) is used, disclosed, and safeguarded in the Reingold Speech Therapy setting. It is designed to ensure compliance with the Health Insurance Portability Act (HIPPA) and to inform you of the privacy rights of you and your child.

Use and Disclosure of Patient Information:

We have created a record of the services and treatment that your child has received at Reingold Speech Therapy. The privacy of your child's medical information is important to us, and we are committed to protecting it. We are required by law to keep medical information private and notify you of legal rights and privacy practices.

What is Protected Health Information (PHI)?

Protect Health Information (PHI) includes any information related to a patient's health status, treatment, or payment for services that can identify the individual who is receiving speech therapy.
This may include:

- Evaluation Reports
- Therapy notes and progress reports
- Audio or video recordings (if applicable)
- Billing and insurance information
- Personal identifiers (name, date of birth, contact details)

How we use and Disclose Information

PHI may be used or disclosed for the following purposes:

1. Treatment
   To provide, coordinate, or manage speech therapy services
   To communicate with other professionals involved in care (e.g., physicians, educators, occupational therapists

2. Payment
   To bill and collect payment from insurance companies or patients
   To verify insurance coverage and obtain authorization for services

3. Healthcare Operations
   For quality assurance and program improvement
   For training, supervision, and administrative purposes

3943 Dahlwiny Court • Atlanta, GA • 30350 • (404) 436-1311 • jen@reingoldspeechtherapy.com

Other Permitted Disclosures
PHI may also be disclosed without authorization in certain circumstances, including:
- When required by law
- To prevent a serious threat to health or safety
- For public health reporting
- For audits, inspections, or investigations

Uses Requiring Authorization
Written consent if required for:
- Sharing information with individuals not directly involved in care
- Use of photographs, videos, or recordings beyond treatment purposes
- Marketing or promotional activities

Patients may revoke authorization at any time in writing

Patient Rights:
Patients have the right to:
- Access Records: Request copies of your child's medical records
- Request amendments: Ask for corrections to inaccurate or incomplete information
- Request Restrictions: Limit how the information is used or disclosed
- Confidential Communication: Request communication through specific methods (e.g., email, phone)
- Receive an Accounting of Disclosures: Obtain a list of certain disclosures made
- File a complaint: If you believe your child's privacy rights have been violated

Safeguarding Patient Information
We implement appropriate safeguards to protect PHI, including:
- Secure electronic record systems with password protection
- Locked storage for paper files
- Limited access to authorized personnel only
- Staff training on confidentiality and privacy practices

Breach Notification
In the event of a breach involving unsecured PHI, patients will be notified promptly in accordance with HIPPA regulations.

Contact Information
For questions about privacy practices or to exercise your rights, please contact Reingold Speech Therapy Services.

Acknowledgment of Receipt

3943 Dahlwiny Court • Atlanta, GA • 30350 • (404) 436-1311 • jen@reingoldspeechtherapy.com

Patients will be asked to sign an acknowledgment confirming they have received and understand this notice of privacy practices.

Confidentiality of Patient Information
Reingold Speech Therapy Services will attempt in all cases to preserve the confidentiality of all oral and written medical information. This includes patient records, written information, and electronic transmission of information to physicians, insurance companies, state and federal entities and law enforcement agencies in the interest of public safety.

Patient Personal Communication
Reingold Speech Therapy Services may communicate confidential information, including photos or videos of delivered services, insurance information, appointment reminders, evaluations, and documentation to designated caregivers below:

PARENTS/GUARDIAN:

Name/Relationship to Child:____

Mailing Address:____

Phone:_____________________ Fax:_________________ Email:_____________________

ADDITIONAL CAREGIVER: (Nanny, Babysitter, Grandparent)

Name/Relationship to Child:____

Mailing Address: ____

Phone: _____________________ Fax: _________________ Email: _____________________

OTHER PROFESSIONALS/SCHOOLS/SPECIALISTS

Name (or title) and organization: ____

Mailing Address: ____

Phone: _____________________ Fax: _________________ Email: _____________________

INSURANCE AND PAYMENT POLICY INFORMATION:

3943 Dahlwiny Court • Atlanta, GA • 30350 • (404) 436-1311 • jen@reingoldspeechtherapy.com

Billing: Statements will be sent the last week of each month for prior months self-pay charges, co-pays, and services that have been processed by insurance.

Insurance: As an added value to clients, Reingold Speech Therapy utilizes a third-party billing service to submit claims to insurance companies on your behalf at no additional charge. We encourage our clients seeking insurance benefits to review the following:

1. Check with your insurance company to find out what speech and language services are covered.

2. Find out what information your insurance company requires. You may need a referral, pre-authorization, and /or a prescription for evaluation and treatment. However, referrals and pre-authorizations do not guarantee that insurance will pay for services.

3. Provide Reingold Speech Therapy with your insurance information by completing this form as well as a copy **(Front & Back)** of your insurance card. You will need to update us with this information should your policy change.

If patient is covered by insurance complete the following information:

Insurance Company:	
ID Number:	Group Number:
Subscriber Name:	
Relationship to Patient:	Date of birth of Subscriber:

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Reingold Speech Therapy, LLC**.** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize Reingold Speech Therapy, LLC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

3943 Dahlwiny Court • Atlanta, GA • 30350 • (404) 436-1311 • jen@reingoldspeechtherapy.com

I understand that I must notify Reingold Speech Therapy, LLC immediately should there be a change in insurance or personal information. Failure to do so will result in my responsibility for payment of services if insurance denies services due to lack of authorization and/or verification of benefits.

I understand that verification of benefits does not ensure payment of services and I am financially responsible for any balance due.

Billing Invoices: Each child's visit is documented by their therapist and reviewed by the clinic director before we submit a claim to your insurance company. Additionally, insurance companies may take 4-6 weeks or more to make payments. After receiving an EOB and/or payment from the carrier, any remaining balance due by patient, will be billed monthly. As a result, you may not receive a billing statement until 4-6+ weeks after a visit. We will give you an estimate of your expected rate per visit during intake. Please be aware of this estimate to avoid a surprise when the invoice arrives with multiple dates of service at a time.

Visit Limits: Most insurance plans have a defined visit limit for therapy. Many limits are combined with other therapies and received at other facilities. Patients are responsible for understanding their policy limits and tracking the number of visits incurred. If your child has a therapy visit beyond the plan limits, you are responsible for the full cost of that visit.

Signature of Responsible Party (type full name):

Relationship to Patient:

Date:

Parental/Guardian Consent & Office Policies

1. **Consent to Treat:** As parent/guardian, I consent for therapists employed by Reingold Speech Therapy to provide my child with speech-language therapy including assessment and intervention. The assessment may include: observation of the child; formal and informal testing; follow up visits; and ongoing intervention. I understand that the results of the Assessment and the Plan of Care will be shared with me. I agree to comply with the Plan of Care with the best of my ability for the best outcome for my child. I understand that at any given time I have the right to refuse care and revoke my consent for treatment with Reingold Speech Therapy, LLC.

3943 Dahlwiny Court • Atlanta, GA • 30350 • (404) 436-1311 • jen@reingoldspeechtherapy.com

2. **Other Consent:** As the parent or legal guardian of the patient, I give authorization for the person(s) named below to bring my child to the evaluation/therapy sessions in my absence. I also give permission for the therapist to discuss the current treatment procedures and/or release records to the people listed below. This is in compliance with HIPAA and is designed to safeguard the privacy and security of the named patient's health information.

   Name: __________________ Relationship: _____________________

   Name: __________________ Relationship: _____________________

3. **Consent to Email Protected Health Information:** I consent for employees and contracted therapists working for GASLC to send any and all protected health information regarding my child or myself via email, which includes but is not limited to evaluations, treatment notes, weekly session updates, progress notes, etc.

   ☐Yes ☐No

4. **Cancellation/Termination Policy:** Reingold Speech Therapy reserves the right to charge a fee for any appointment that is not kept or not cancelled by giving 24-hour notice. Unforeseen circumstances are anticipated and will be handled on a case-by-case basis. If you plan to dismiss your child or yourself from therapy, a 2-week notification is required unless otherwise agreed upon. Should you choose to end treatment without two-week notification, you will be responsible for paying for all services that would have been provided in those two weeks. Initialing below notifies Reingold Speech Therapy that you agree to the above cancellation and termination policies.

   Initial Here: ______________

TEXT MESSAGING TERMS OF SERVICE

As parent/guardian, I consent to receive text messages from Reingold Speech Therapy for appointment reminders, marketing messages, and general two-way communication, including potentially for administrative issues, such as billing, or for health-related issues, such as care reminders. I understand that text messaging may not be secure and will initiate a request in writing to Reingold Speech Therapy if I prefer another communication method.

3943 Dahlwiny Court • Atlanta, GA • 30350 • (404) 436-1311 • jen@reingoldspeechtherapy.com

I agree to receive (I "opt in" to receiving) text messages from Reingold Speech Therapy, related to services provided. Message and data rates may apply, and message frequency varies. I may text STOP at any time to opt out of receiving text messages.

Name of Child: (First & Last Name): ______________________________

Parent/Guardian: (First & Last Name): ______________________________

Phone Number: ______________________________

Date: ______________________________

Signature(Type Full Name): ______________________________