PATIENT INFORMATION FORM

PATIENT NAME: _____ DOB: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

MEDICAL DIAGNOSIS: _____

MOTHER NAME: _____

PHONE: _____ CELL: _____WORK PHONE: _____

EMAIL: _____

FATHER NAME: _____

PHONE: _____CELL: _____ WORK PHONE: _____

EMAIL: _____

WHO RESIDES IN YOUR CHILD'S HOUSEHOLD: _____

NEAREST RELATIVE IF UNABLE TO CONTACT YOU: _____

PHONE: _____

WHAT IS THE BEST WAY TO CONTACT YOU REGARDING APPOINTMENTS/SCHEDULING?

☐ PHONE CALL ☐ TEXT ☐ EMAIL

IF SOMEBODY REFERRED YOU (INCLUDING DOCTOR OFFICES) PLEASE PROVIDE THEIR INFORMATION, WE WOULD LIKE TO SHOW OUR GRATITUDE BY SENDING THEM A GIFT! ☺

REFERRED BY: _____ PHONE: _____

ADDRESS: _____

PHYSICIAN NAME: _____ PHONE: _____

PRIMARY INSURANCE: _____

Please describe reason for evaluation:

_____

_____

_____

_____

_____

_____

(2/3) CHILD'S NAME: _____

THERAPY PRECAUTIONS-Please be specific

	Yes	No	Comments
1. Does your child have any food allergies? Please list.	**Y**	**N**	
2. Does your child have a history of seizures? If so, when did the last seizure occur?	**Y**	**N**	
3. Please describe any other precautions that are not mentioned above._____	**Y**	**N**	

PREGNANCY AND BIRTH HISTORY

	Yes	No	Comments
1. Were there any illnesses, injuries, bleeding, or any complications during this pregnancy? Describe:	**Y**	**N**	
2. Was this pregnancy full-term? If not, please give gestational age and weight at time of delivery.	**Y**	**N**	
3. Were there difficulties with feeding?	**Y**	**N**	
4. Did your child have difficulties sucking?	**Y**	**N**	
5. Does your child have any siblings? * If so, Number of siblings? _____ * Do siblings have any pertinent medical history or history of language disorder? _____	**Y**	**N**	
6. Please describe any pertinent birth history not mentioned above. _____	**---**	**---**	

MEDICAL HISTORY

Has your child had any of the following:	Yes	No	Comments
1. Frequent Ear infections	**Y**	**N**	
2 Excessive vomiting or reflux.	**Y**	**N**	
3. Asthma	**Y**	**N**	
4. Vision problems?	**Y**	**N**	
5. Hearing problems?	**Y**	**N**	
6. Is your child on any medications? Please list.	**Y**	**N**	
7. Please describe any pertinent medical conditions not mentioned above. _____	**---**	**---**	

SENSORY HISTORY

Does your child have any difficulties with the following:	Yes	No	Comments
1. Eating a variety of age appropriate foods and textures	**Y**	**N**	
2. Drooling	**Y**	**N**	
3. Chewing/swallowing food	**Y**	**N**	
4. Tolerating tags/clothing/shoes	**Y**	**N**	
5. Playing in grass, sand, or dirt	**Y**	**N**	
6. Tolerating dirty hands/face when eating and/or playing	**Y**	**N**	
7. Being strapped into a car seat or booster seat	**Y**	**N**	
8. Tolerating hair being brushed/washed	**Y**	**N**	
9. Flap hands, jump, or spin when excited?	**Y**	**N**	
9. Attending to tasks?	**Y**	**N**	
10. Please describe any pertinent sensory condition not mentioned above. _____	**---**	**---**	

(3/3) CHILD'S NAME: _____

SPEECH AND LANGUAGE HISTORY

Does your child:	Yes	No	Comments
1. Use words to communicate needs/wants	**Y**	**N**	
2. Follow simple directions (e.g. "get your shoes")	**Y**	**N**	
3. Follow complex directions (e.g. "push in your chair and throw away your garbage.")	**Y**	**N**	
4. Mispronounce words/sounds when communicating?	**Y**	**N**	
5. Repeat words when getting his/her point across (e.g. "can, can, can I go too?")	**Y**	**N**	
6. Make eye contact when communicating or when talked to?	**Y**	**N**	
7. Respond to his/her name when called?	**Y**	**N**	
8. Play well with other peers his/her age?	**Y**	**N**	
9. Play appropriately with a variety of age appropriate toys?	**Y**	**N**	
10. Prefer to play with one type of toy/action figurine	**Y**	**N**	
11. Please describe any pertinent speech and language condition not mentioned above. _____	**Y**	**N**	

GROWTH AND DEVELOPMENT

At what age did your child first:

Sit alone_____ Feed self finger foods_____

Crawl (hands & feet)_____ Speak first real words _____

Stand alone _____Speak first real sentences _____

Walk well _____Become completely toilet trained_____

SCHOOL/DAYCARE HISTORY

(if not applicable please check: ☐ NOT APPLICABLE)

School/Daycare name: _____Grade/Class: _____

Please describe child's performance at school/daycare. What areas/subjects does your child do well in? What areas/subjects does your child have difficulty with?

_____

_____

_____

Does your child exhibit behaviors at home or school that concern you? Please explain:

_____

_____

_____

Parent/Guardian print name_____

Parent/Guardian signature_____ **Date**: _____

Patient Name: _____ Date of Birth: _____/____/_____

1. *Medical Information Release Form (HIPAA Release Form)*

Release of Information (Please check boxes that apply and provide names)
I authorize C.A.P. Speech Therapy and all its employees to discuss, release, and/or receive medical information including but not limited to: all aspects of patient's medical records to process claims including medical and billing information and information related to completing speech language pathology services; evaluation/plan of care, therapeutic progress, therapeutic strategies and techniques, and any other information that may increase the quality of care for the child.
This information may also be released to:
[ ] Academic Institution (must be checked if child is being treated in school/daycare)
[ ] Any caregiver/adult that is bringing my child to therapy

Any individuals or entities that I do NOT want my health information released to are listed specifically below:

This authorization will EXPIRE upon my discharge from patient services or upon my written request to deny future releases.

*** Parent/Guardian Signature _____ Date: _____/_____/_____**

2. Messages
I authorize you to call **[ ]** my home **[ ]** my work **[ ]** my cell
for therapeutic reasons including but not limited to: appointments, scheduling, progress, and other related issues.

I authorize you to:
[ ] send a text message (easiest and fastest way to confirm appointments)

*** Parent/Guardian Signature _____ Date: _____/_____/_____**

Consent for Care and Treatment
I, the undersigned, do hereby agree to give my consent for C.A.P. Speech Therapy to furnish therapeutic services for the above listed patient.

*** Parent/Guardian Signature _____ Date: _____/_____/_____**

CAP
Center for **A**dvanced **P**ediatric
Speech Therapy
p. 786.571.5322 f. 786.541.1503
www.capspeech.com info@capspeech.com

Patient Name: _____ Date of Birth: _____/____/_____

3. PHOTO RELEASE AGREEMENT

I hereby authorize Center for Advanced Pediatric Speech Therapy hereafter referred to as C.A.P. Speech Therapy, to publish photographs taken of my child during therapy sessions for use in the C.A.P. Speech Therapy's print, online and video-based marketing materials, as well as other Company publications and educational/staffing meetings.

I hereby release and hold harmless C.A.P. Speech Therapy from any reasonable expectation of privacy or confidentiality associated with the images specified above. I release C.A.P. Speech Therapy, its contractors, its employees, and any third parties involved in the creation or publication of marketing materials, from liability for any claims by me or any third party in connection with my participation.

Authorization:
*** Parent/Guardian Signature _____ Date: _____/_____/_____**
☐ I do not authorize a photo release at this time.

4. Receipt of Notice of Privacy Practices

I _____ have reviewed/received a copy of C.AP. Speech Therapy's
(parent/guardian name)
Notice of Privacy Practices read and agree to the terms of the notice of privacy practices.

_____ _____
Parent/Guardian Signature Date

5. Receipt of Company Policies

I have read and/or received a copy of the company policies and I agree to the terms stated.

_____ _____
Parent/Guardian Signature Date

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Dear Client,

Thank you for allowing us to serve your child. As a convenience to you, we are accepting credit cards as our primary payment method. Because of the nature of this service we will need the right to ACH (electronic payments made through the Automated Clearing House Network), or run charges on your credit card to pay for our services. You will be charged on a weekly or biweekly basis. You will be sent your copy of the receipt for every transaction for your records.

Your information is stored in a triple DES encrypted gateway. Our staff and no one else has access to this information. Please sign to verify your knowledge of this procedure and let us know the e-mail address where you want us to send the receipt.

The preferred payment method is debit, but we are also accepting MasterCard and Visa.
_____ Debit _____ MasterCard _____ Visa

Name on card: _____
Billing Address:_____City:_____State:____Zip:_____
E-mail for receipt:_____
Debit/Credit Card Number: _____
Expiration Date: _____

_____ _____
Signature Date

Thank You,

Melanie Cap
Director

CAP
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www.capspeech.com info@capspeech.com