



Speech-Language Pathology

2016-2017

Intake Packet

- **Speech Case History**
- **Authorization for Medical Attention**
- **Consent For Treatment**
- **Speech Payment Contract & Authorization**
- **Carruth Center Policies**
- **Release of Information TPS / Carruth**
- **Schedule of Fees**



THE CARRUTH CENTER
AT THE PARISH SCHOOL

Speech Case History

Date: _____

Information provided by: _____

Child's Name: _____

First

Middle

Last

Name Called

Address: _____

Home Telephone Number: _____

Birth Date: _____ Age: _____ Gender: Male Female

Who has legal custody of this child? _____

Is this child adopted? _____ At what age? _____ Is he/she aware of this? _____

Father: _____ Date of Birth: _____

Home Address: _____
(if different) _____ City _____ State _____ Zip Code _____

Contact Numbers: Home _____ Work _____ Cell#: _____

Email Address: _____

Marital Status: _____

married to child's mother (biological or adoptive), single, separated, divorced, widowed, remarried

PLEASE NOTE IF YOU ARE DIVORCED WE WILL NEED A COPY OF YOUR DIVORCE DECREE

Occupation: _____ Place of Occupation: _____

Business Address: _____

Education/Highest Degree: _____

Mother: _____ Date of Birth: _____

Home Address: _____
(if different) _____ City _____ State _____ Zip Code _____

Contact Numbers: Home _____ Work _____ Cell#: _____

Email Address: _____

Marital Status: _____

married to child's father (biological or adoptive), single, divorced, widowed, remarried

Occupation: _____ Place of Occupation: _____

Business Address: _____

Education/Highest Degree: _____

Please list the occupants of your child's:

Household 1: _____

Household 2: _____

Name	Age	Relationship to child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name	Age	Relationship to child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is any language other than English spoken in the home? _____ Which? _____

Who referred you to The Carruth Center? _____

FAMILY HEALTH HISTORY, MENTAL ILLNESS, AND/OR DEVELOPMENTAL PROBLEMS:

Please check Yes or No for each of the medical conditions below which apply to a family member, then list relation to the right (e.g., mother, brother, paternal grandfather, maternal uncle, etc.)

- | | | |
|--------------------------|--------------------------|--|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Vision Problems _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Defects _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental Retardation/Down's Syndrome _____ |

- | | | |
|--------------------------|--------------------------|------------------------|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Sudden Death _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing Problems _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cerebral Palsy _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes _____ |

Please list any other diseases that run in the family:

- | | | |
|--------------------------|--------------------------|---|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Nervous Breakdown _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Emotional Problems _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Delinquency Problems _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Substance Abuse _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcoholism _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Bed Wetting after 5 yr. _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hyperactivity/ADHD _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Schizophrenia _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Learning Problems: Please specify _____ |

- | | | |
|--------------------------|--------------------------|--|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Bipolar Disorder _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Autism/PDD _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Speech Problems/Delays _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Eating Problems (anorexia/bulimia) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Post-partum Depression _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Obsessive Compulsive Disorder _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Phobias _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: Please specify _____ |

CURRENT CONCERNS:

Please check below if you have any concerns about your child in these areas:

- | | | |
|--|--|---|
| <input type="checkbox"/> Short Attention Span | <input type="checkbox"/> Attention seeking | <input type="checkbox"/> Distractibility |
| <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Avoidance |
| <input type="checkbox"/> Low frustration tolerance | <input type="checkbox"/> Noncompliance | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Oppositional behavior | <input type="checkbox"/> Social Isolation | <input type="checkbox"/> Low self-esteem |
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Lying | <input type="checkbox"/> Awareness of differences |
| <input type="checkbox"/> Difficulties with transitions | <input type="checkbox"/> Self-stimming | <input type="checkbox"/> Difficulties separating |

Please list any additional concerns about your child: _____

When did these problems begin? _____

PRE AND PERI-NATAL HISTORY:

Was this a planned pregnancy: Yes No Fertility? _____

MEDICAL HISTORY DURING PREGNANCY:

Please answer which of the following conditions may have occurred during this pregnancy and explain in the space below:

- | | | | | | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|---|
| Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Edema (swelling of the hands and feet) | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy (Seizure) |
| <input type="checkbox"/> | <input type="checkbox"/> | Vaginal Bleeding | <input type="checkbox"/> | <input type="checkbox"/> | Infections (colds, flu, urinary tract, rubella) |
| <input type="checkbox"/> | <input type="checkbox"/> | Toxemia | <input type="checkbox"/> | <input type="checkbox"/> | Other Illnesses |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Tobacco/Alcohol/Controlled Substance use |
| <input type="checkbox"/> | <input type="checkbox"/> | X-ray studies | | | Frequency: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hospitalization | | | Injuries (specify): _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Operations (specify): _____ | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |

Please explain all **Yes** answers: _____

BIRTH HISTORY:

Length of Labor: _____

- Type of Labor Onset: Induced Spontaneous
 Type of Birth: C/Section Vaginal
 Type of Anesthesia: Gas Spinal (epidural) Local
 Was the baby on time? Yes No
 If No, was he/she Early or Late, and by how many weeks? _____

Age of Father at birth: _____ Age of Mother at birth: _____ Number of Children Born: _____

Does either parent have children from previous relationships? If so, please list names & ages below:

Mother: _____

Father: _____

Problems during Labor:

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Toxemia/Eclampsia	<input type="checkbox"/>	<input type="checkbox"/>	Fetal Distress
<input type="checkbox"/>	<input type="checkbox"/>	Maternal Fever	<input type="checkbox"/>	<input type="checkbox"/>	Medications Used

How much did your child weigh? _____

Apgar Scores: _____

Check if any of the following problems occurred after the child's birth and explain in the space below:

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Trouble Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	Cord around the Neck	<input type="checkbox"/>	<input type="checkbox"/>	Poor Feeding
<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhage (Bleeding) in Head	<input type="checkbox"/>	<input type="checkbox"/>	Floppy
<input type="checkbox"/>	<input type="checkbox"/>	Large Ventricles (Hydrocephalus)	<input type="checkbox"/>	<input type="checkbox"/>	Incubator Care
<input type="checkbox"/>	<input type="checkbox"/>	Cyanosis (turned blue)	<input type="checkbox"/>	<input type="checkbox"/>	Infection
<input type="checkbox"/>	<input type="checkbox"/>	Need for Ventilation/Oxygen	<input type="checkbox"/>	<input type="checkbox"/>	Other

Please explain all **Yes** answers: _____

How many days after birth was mother discharged from hospital? _____

How many days after birth was child discharged from hospital? _____

Previous Obstetrical History:

How many full-term pregnancies has mother had? _____

What were the dates? _____

Any abortions, miscarriages, or still births? _____

What were the dates? _____

CHILD DEVELOPMENT:

Was your child breast-fed? Yes No

Duration? _____

Describe the circumstances around stopping: _____

Describe the weaning: _____

Was your child bottle-fed? Yes No

Duration? _____

Describe the circumstances around stopping: _____

Please check any of the following that described your child as an infant:

- | | | |
|--|--|--|
| <input type="checkbox"/> Fussy | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Easy to soothe | <input type="checkbox"/> Feeding problems | <input type="checkbox"/> Failure to Thrive |
| <input type="checkbox"/> Difficult to soothe | <input type="checkbox"/> Cried excessively | <input type="checkbox"/> RSV |
| <input type="checkbox"/> Startled easily | <input type="checkbox"/> Colic | <input type="checkbox"/> Other _____ |

What are your child's sleeping arrangements?

- Room alone With sibling With parents With others

Does your child sleep in crib bed

Does he/she sleep through the night? Yes No

If not, how many times does he/she awaken at night? _____

For how long? _____

What helps him/her get back to sleep? _____

Did/Does your child have a special object (blanket, teddy bear, etc.)? Yes No

If yes, please describe _____

If yes, until what age? _____

Does he/she have any self-soothing behavior? Yes No

If yes, does he/she suck fingers/thumb use pacifier twirl hair

other, please describe _____

Does your child exhibit any behaviors that you consider 'odd' or 'unusual'? _____

How many hours of TV and/or video does your child watch each day? _____

What are his/her favorites? _____

Developmental Milestones: (age of mastery)

When did your child do the following (Please list specific age if possible):

	Early?	Late?	On time?	AGE
Smile	_____	_____	_____	_____
Laugh	_____	_____	_____	_____
Maintain eye gaze	_____	_____	_____	_____
Imitation	_____	_____	_____	_____
Gestures (pointing)	_____	_____	_____	_____
Roll over	_____	_____	_____	_____
Sit	_____	_____	_____	_____
Crawl	_____	_____	_____	_____
Stand	_____	_____	_____	_____
Walk	_____	_____	_____	_____
Wave Bye-Bye	_____	_____	_____	_____
Toilet Trained (day)	_____	_____	_____	_____
(night)	_____	_____	_____	_____
Babbling	_____	_____	_____	_____
Cooing	_____	_____	_____	_____

First words _____

What were your child's first words? _____

When did your child put two words together? _____

Could you understand your child's speech by age 2? Yes No

Could others understand your child's speech by age 2? Yes No

Could your child speak in simple sentences by age 2? Yes No

How does your child typically communicate? Gesture Words Sentences

Does your child recite scripts from movies or TV? Yes No

Please describe any areas of concern (articulation, socialization, receptive language, expressive language, echolalia (parroting what is said)):

When did your child:

	Early	Late	On time	AGE
Use writing utensils	_____	_____	_____	_____
Use eating utensils	_____	_____	_____	_____
Run smoothly	_____	_____	_____	_____
Snap	_____	_____	_____	_____
Button	_____	_____	_____	_____
Zip	_____	_____	_____	_____
Jump with 2 feet	_____	_____	_____	_____
Tie Shoes	_____	_____	_____	_____
Climb play equipment	_____	_____	_____	_____
Ride a bike: tricycle	_____	_____	_____	_____
Training wheels	_____	_____	_____	_____
Two-wheeler	_____	_____	_____	_____
Skip with coordination	_____	_____	_____	_____

Please describe any areas of concern (i.e., fine or gross motor, balance) _____

Did your child do any head banging? _____ At what age? _____

Is he/she left-handed or right-handed? _____ Does he/she change from hand to hand? _____

MEDICAL HISTORY:

Child's Physician: _____ Telephone #: _____

What major illnesses, hospitalizations, or operations has your child had? Please explain when the incident happened, what occurred, and how your child and each parent experienced this event.

Do you have any concerns about your child's physical health? Yes No

If YES, please describe: _____

When was your child's last physical exam? _____ Where? _____

Please check which of the following your child has had and note the age, complications and frequency below:

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	measles	<input type="checkbox"/>	<input type="checkbox"/>	mumps
<input type="checkbox"/>	<input type="checkbox"/>	chicken pox	<input type="checkbox"/>	<input type="checkbox"/>	pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	whooping cough	<input type="checkbox"/>	<input type="checkbox"/>	viral infections
<input type="checkbox"/>	<input type="checkbox"/>	trauma (broken bones/stitches)	<input type="checkbox"/>	<input type="checkbox"/>	hospitalizations
<input type="checkbox"/>	<input type="checkbox"/>	concussions (age and treatment)	<input type="checkbox"/>	<input type="checkbox"/>	surgery
<input type="checkbox"/>	<input type="checkbox"/>	hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	asthma
<input type="checkbox"/>	<input type="checkbox"/>	allergies	<input type="checkbox"/>	<input type="checkbox"/>	tremor
Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	meningitis (viral/bacterial)	<input type="checkbox"/>	<input type="checkbox"/>	RSV
<input type="checkbox"/>	<input type="checkbox"/>	persistent high fever	<input type="checkbox"/>	<input type="checkbox"/>	coma
<input type="checkbox"/>	<input type="checkbox"/>	convulsions	<input type="checkbox"/>	<input type="checkbox"/>	head trauma
<input type="checkbox"/>	<input type="checkbox"/>	loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>	pica (eating nonfood items, such as dirt or paper)
<input type="checkbox"/>	<input type="checkbox"/>	staring spells	<input type="checkbox"/>	<input type="checkbox"/>	bed wetting
<input type="checkbox"/>	<input type="checkbox"/>	accidental poisoning	<input type="checkbox"/>	<input type="checkbox"/>	stool soiling
<input type="checkbox"/>	<input type="checkbox"/>	vision problems	<input type="checkbox"/>	<input type="checkbox"/>	bowel problems
<input type="checkbox"/>	<input type="checkbox"/>	floppy	<input type="checkbox"/>	<input type="checkbox"/>	falls frequently
<input type="checkbox"/>	<input type="checkbox"/>	seizures	<input type="checkbox"/>	<input type="checkbox"/>	excessive vomiting
<input type="checkbox"/>	<input type="checkbox"/>	headaches	<input type="checkbox"/>	<input type="checkbox"/>	anemia
<input type="checkbox"/>	<input type="checkbox"/>	ear infections (how many?) _____	<input type="checkbox"/>	<input type="checkbox"/>	medication for convulsion
<input type="checkbox"/>	<input type="checkbox"/>	other infections:	<input type="checkbox"/>	<input type="checkbox"/>	medication for hyperactivity
<input type="checkbox"/>	<input type="checkbox"/>	tics	<input type="checkbox"/>	<input type="checkbox"/>	medication for other illnesses (not including colds or ear infections)
<input type="checkbox"/>	<input type="checkbox"/>	other long term medical complaints/problems			

Please explain all **YES** answers, including age and treatment for each. _____

Please list all medication your child has taken or is currently taking, and the dosage _____

Has your child had a neurological examination? If so, where and when? What were the results? _____

Has your child had a psychological examination? If so, where and when? What were the results? _____

SOCIAL/BEHAVIORAL HISTORY:

How does your child get along within the family circle? _____

Does your child play well with siblings? _____

Does your child prefer to play alone? _____

Does your child prefer to play with older, younger or same age peers? (Please check)

Is your child aware of his/her difficulties? _____

What are your child's favorite activities? _____

What methods of discipline are used?

- | | |
|---|--|
| <input type="checkbox"/> Rewards | <input type="checkbox"/> Verbal reprimands |
| <input type="checkbox"/> Time out | <input type="checkbox"/> Removal of privileges |
| <input type="checkbox"/> Avoidance of child | <input type="checkbox"/> Physical punishment |
| <input type="checkbox"/> Other _____ | |

What are your child's reactions to discipline? _____

Who is usually responsible for discipline? _____

How would you describe the effectiveness of parenting strategies in your home? _____

Please check all that apply to your child:

- | | |
|---|---|
| <input type="checkbox"/> Quiet | <input type="checkbox"/> Happy |
| <input type="checkbox"/> Sensitive to change in routine | <input type="checkbox"/> Sensitive to loud noises |
| <input type="checkbox"/> Daydreams | <input type="checkbox"/> Withdrawn |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Aggressive |
| <input type="checkbox"/> Sensitive to certain clothing/textures | <input type="checkbox"/> Unusual Fears |
| <input type="checkbox"/> Dislikes being touched | <input type="checkbox"/> Hyperactive |
| <input type="checkbox"/> Resistant to change | <input type="checkbox"/> Affectionate |
| <input type="checkbox"/> Unusual sexual behavior | |
| Other: _____ | |

Please describe the following characteristics in terms of whether the behavior never, sometimes or often occurs:

	Never	Sometimes	Often
Is your child active?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your child loud and noisy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your child have difficulty making transitions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your child sensitive to light?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your child sensitive to smells?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your child cry easily?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your child clingy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can your child entertain him/herself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your child get angry easily?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your child have temper-tantrums?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Never	Sometimes	Often
Is your child shy or slow to warm up to new adults?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your child shy or slow to warm up to new children?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your child physically cautious?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your child take risks that endanger his/her safety?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your child sad?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If your child is aggressive, does he/she			
<input type="checkbox"/> hit <input type="checkbox"/> bite <input type="checkbox"/> kick <input type="checkbox"/> destroy property			
	<input type="checkbox"/> other?	_____	

EDUCATIONAL HISTORY:

Name of current school placement and grade/class: _____

In your child's classroom, what is the number of: Teachers _____

Assistants _____

Students _____

How is your child progressing? _____

Has he/she repeated any grades? If so, which? _____

With what area(s) has your child had particular difficulty? _____

Has your child had special help through the school? If so, describe. _____

How does he/she child feel about school? _____

What are your child's favorite subject(s)? _____

Do you think your child's teacher likes him/her? _____

Does the teacher describe your child with any of the following comments (please check):

	Never	Sometimes	Often
Cannot follow directions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learns best using multi-sensory approach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seems to be daydreaming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learns best auditorily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannot sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learns best visually	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picks on other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has a difficult time expressing his/her thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is aggressive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doesn't seem to comprehend what's said	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is sneaky	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannot complete tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What do you feel are your child's strengths? _____

Other Professionals:

List other professionals (speech/language pathologists, psychologists, psychiatrists, neurologists, tutors, educational diagnosticians, etc.) your child has seen in the past or is currently seeing:

Name	Telephone Number	Dates Under Care In The Past	Current Appointment Days & Times	Reason for seeing
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Has your child ever been in any type of special educational/therapy program, and if so, how long?

	Where	Duration
<input type="checkbox"/> Early Childhood Intervention (ECI)	_____	_____
<input type="checkbox"/> PPCD Class	_____	_____
<input type="checkbox"/> Speech & Language Therapy	_____	_____
<input type="checkbox"/> Physical Therapy	_____	_____
<input type="checkbox"/> Occupational Therapy	_____	_____
<input type="checkbox"/> Psychotherapy	_____	_____
<input type="checkbox"/> Gifted and Talented	_____	_____
<input type="checkbox"/> Other (please specify)	_____	

Please use this area for any additional comments or concerns:



AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION

Child's Name (Print): _____ Date of Birth: _____

Mother's Home #: _____ Father's Home #: _____
Mother's Work #: _____ Father's Work #: _____
Mother's Cell #: _____ Father's Cell #: _____

In the event that we cannot be reached to make arrangements for emergency medical attention, we authorize Karen Dickerson, Clinical Director, or a designated staff member to take my child to:

Doctor _____
Address _____
Phone # _____

Or to the nearest hospital, and we give our consent for any and all necessary treatment. In case of emergency treatment, please inform the medical staff that our child has the following allergies and that our child takes the following medication(s) on a daily basis (include dosage):

Please list two (2) persons whom we may contact in the event of any emergency:

Name Phone Relationship

Name Phone Relationship

Mother's signature Father's signature

Child's Name & Birth date (please print) Date of signatures

THIS FORM MUST BE KEPT UPDATED AT ALL TIMES.



THE CARRUTH CENTER
AT THE PARISH SCHOOL

Consent for Treatment

Client: _____ Date of Birth: _____

Parent/Guardian: _____ Relationship to Client: _____

I, _____, hereby give consent for the above named child and/or myself to receive services at the Carruth Center of The Parish School. This consent is given until I give notice that these services are no longer requested or until Carruth Center of The Parish School professionals notify me these services will no longer be provided. I certify that I have legal responsibility for this child and am authorized to seek and consent treatment for him/her. I understand that all information provided to Carruth Center of The Parish School professionals is confidential and will generally be released to others only with my written consent. I understand that Carruth Center of The Parish School professionals are required to disclose confidential information without my consent in certain circumstances which includes, but is not limited to, 1) if it is determined there is a probability of imminent physical injury by my child to himself/herself or other(s), or if there is a probability of immediate mental or emotional injury to my child 2) if the disclosure is required or authorized by law, legal proceedings, or court order 3) to qualified individuals, corporations, or governmental agencies involved in paying or collecting fees for mental or emotional health services for my child 4) to other professionals and personnel, under the direction of Carruth Center of Parish School professionals providing services to my child, who participate in the diagnosis, evaluation, or treatment of my child 5) a judicial or administrative proceeding brought against Carruth Center of The Parish School professionals by myself or my child 6) in the event it is believed my child is the victim of physical abuse, sexual abuse, or neglect, or if my child divulges information about the physical abuse, sexual abuse, or neglect of a child, elder, or disabled person.

The professionals rendering services through Carruth Center of The Parish School are dedicated to using established and empirically supported psychological, behavioral, and educational evaluation and intervention procedures to optimize the social, emotional, and cognitive development of each child. In the event a child presents as an immediate danger to himself/herself, others, or property, the least restrictive intervention shall be utilized to provide safety for the child, others, or property. While verbal mediation will be the primary intervention utilized, at times physical contact may be required to provide safety for the child, others, or property. At these times, a "therapeutic hold" will be used to help manage a child's behavior until verbal mediation can effectively be used to address the situation and/or until the child no longer presents as an immediate danger to himself/herself, others, or property.

My signature on this document indicates I have read the above information and have a clear understanding of the procedures, policies, and therapeutic interventions described. I have been given the opportunity to have my questions answered regarding the above-described information. I understand that I have the right to withdraw treatment for my child at any time.

Signature of Parent/Guardian

Date

Witness

Date



THE CARRUTH CENTER
AT THE PARISH SCHOOL

PAYMENT CONTRACT & AUTHORIZATION
Speech Language

Client's (Childs) Name: _____

The fees for the Speech/Language Therapy sessions are invoiced on or around the **5th** day of the month following the last session of the previous month. Payment for these sessions will be direct debited from your account or charged to your credit card on or around the **15th** day of the following month (or the next business day), depending on the selection below and payment authorization information provided.

Speech/Language Evaluation with a report is \$350.00.

Individual Speech/Language Therapy is \$130.00 per hour session

_____ Please charge my **credit card** (complete the credit card authorization on following page).

_____ Please **direct debit** my account (complete the ACH direct debit on following page).

In consideration for the acceptance and enrollment of _____ in individual treatment, or group program, I (we) the undersigned parent(s), and/or guardian, or other endorser hereof, promise to pay to the order of Carruth Center, Inc. all applicable fees charged for services rendered due on/or before the fifteenth of the month following treatment. Outstanding balances may result in suspension of services until total account balance has been cleared. There will be a \$20.00 service charge for NSF checks.

_____ I understand that the form or payment on file must be kept current. To update your form of payment on file, submit a new "Payment Contract & Payment Authorization" form to the Carruth Center, Inc. Business Office before the 15th of the month.

_____ I authorize the Carruth Center, Inc. to charge the agreed upon credit card or ACH debit on or around the 15th of each month for services provided during the previous months (generally on going individual services) OR on the dates specified in the payment option selected on the signed contract for services (generally group therapy).

_____ I agree that if initial payment processing is declined for any reason, Carruth Center, Inc. may continue to process the payment against the card on a regular basis, until the payment is successfully processed and the balance is resolved. Reoccurring payment declines will result in payments being due at the time of service. In this circumstance acceptable form of payment would be exact cash or a credit card that can be successfully processed at the time of service.

_____ I acknowledge and understand the cancellation, late arrival, and late pick-up policies. See Carruth Center Policies form.

See reverse side for payment authorization form
Carruth Center, Inc. must have a current form of payment on file for all clients.



THE CARRUTH CENTER

AT THE PARISH SCHOOL

PAYMENT CONTRACT & AUTHORIZATION

Client's (Childs) Name: _____

Credit Card Authorization

_____ Visa _____ MasterCard _____ American Express _____ Discover

Credit Card Number: _____

Expiration Date: _____ Card Security Code (CSC): _____

Name on Card: _____

Address: _____

ZIP Code: _____

Phone Number: _____

ACH Direct Debit Authorization

_____ Checking Account _____ Savings Account

Depository Name _____ Branch _____

City _____ State _____ Zip _____

Routing Number _____ Account Number _____

_____ I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. Law.

Attach a blank voided check

This Authorization is to remain in full force and effect until Carruth Center, Inc. has received written notification from me (I or either of us) of its termination in such time and in such manner as to afford Carruth Center, Inc. and DEPOSITORY a reasonable opportunity to act on it.

Print Name: _____

Date: _____ Signature: _____



THE CARRUTH CENTER
AT THE PARISH SCHOOL

Carruth Center Policies

Client's (Childs) Name: _____

Please read carefully. **Both parents or guardians** are required to initial each line.

____ **Clinic Visitation Policy:**

- Children must be accompanied by an adult in the lobby at all times.
- Please check in with Carruth Center, Inc. office before entering the therapy area. All parents and visitors must wear a visitor badge while in the Carruth Center, Inc. therapy area.
- Group observations must be scheduled through the Carruth Center, Inc. business office at least 24 hours in advance.

____ **Cancellation Policy:**

The undersigned hereby acknowledges that failure to cancel a scheduled treatment session or a parent conference 24 hours in advance of the scheduled appointment will result in a 100% charge for the allocated session fee. Carruth Center, Inc. administration reserves the right to dismiss a client from therapy for inconsistent attendance. In addition, the undersigned hereby acknowledges that Carruth Center, Inc. reserves the right to withhold all test results and reports when professional fees are not paid as per above.

- **No show/no call cancellation:** The undersigned hereby acknowledges that failure to notify the treating clinician to cancel a scheduled treatment session will be considered a no show/no call appointment. We ask that all cancellations, not due to illness or a family emergency be made 24 hours in advance. A no show/no call appointment will result in a 100% charge for the allocated session fee.
- **Late Cancellation:** The undersigned hereby acknowledges that any cancellation, not due to illness or family emergency, that is made **less** than 24 hours in advance is considered a late cancellation. A late cancellation will result in a 100% charge for the allocated session fee.



Late Pick-up Policy:

The undersigned hereby acknowledges that parents are expected to be in the Carruth Center, Inc. lobby or front porch area prior to the end of their child’s therapy session. Carruth Center, Inc. late-pick up policy is as follows:

- Client families will be given 2 “passes” (no charge assessed) per fiscal year (August 1st - July 31st) for unexpected tardies not to exceed 5 minutes.
- Late pick-ups **BEYOND** 5 minutes **OR** post 2 “passes” will be charged per the quarter-hour at the standard individual therapy rate.
- Chronic tardiness may lead to parent being required to remain present on campus throughout therapy session.

Breakdown of Late Fees according to therapy discipline

Standard Speech, OT, Music Individual Therapy Sessions	Standard Individual Therapy Rate (\$130.00)	Standard Mental Health Individual Therapy Sessions	Standard Mental Health Individual Therapy Rate (\$140.00)
5-15 minutes	\$32.50	5-15 minutes	\$35.00
15-30 minutes	\$65.00	15-30 minutes	\$70.00
31-45 minutes	\$97.50	31-45 minutes	\$105.00
46 – 60 minutes	\$130.00	46 – 60 minutes	\$140.00

*standard mental health therapy hour is 45 minutes for children, and 50 minutes for adults)

- Late fees will be included in the monthly invoice. Failure to resolve fees with regularly scheduled, monthly payment processing, on or around the 15th of every month, will result in suspension of client services.
- Late pick up fees are not eligible for insurance reimbursement.

Late Start Policy:

The undersigned hereby acknowledges that late arrivals will not be accommodated by extension of therapy time. Full session fee will apply to late arrivals. For example: If a client is 5 minutes late to their scheduled appointment time, the result will be a 30-minute session fee, even though it was only a 25-minute therapy session.

- Clients are encouraged to arrive to the Carruth Center, Inc. lobby 2 to 5 minutes prior to their scheduled session time.



____ Policy on Insurance:

- Carruth Center, Inc. is a fee-for-service facility and families are responsible for all payments.
- Carruth Center, Inc. does not guarantee coverage and/or the ability to gain coverage of services. Coverage is determined by your individual policy.
- Carruth Center, Inc. is considered out-of-network, and therefore, we ask that families act as the liaison for any direct communication with their insurance companies.
- Carruth Center, Inc. does not submit claims on behalf of the client.
- Carruth Center, Inc. provides invoices and or services provided forms with necessary codes, clinician information, and clinic information for your convenience and ease of filing claims.
- Carruth Center, Inc. does not accept payment from insurance companies. All insurance checks issued to the Carruth Center, Inc. are returned to the insurance company with a request to issue payment to the insured. The insured is then notified by letter and copy of the check for their records.

Parent Name _____
(Print):
Signature: _____

Date: _____

Parent Name _____
(Print):
Signature: _____

Date: _____



THE CARRUTH CENTER
AT THE PARISH SCHOOL

AUTHORIZATION FOR REQUEST/RELEASE OF INFORMATION

Child's Name: _____

I hereby authorize:

Randi Raizner, PhD.	_____	initial to consent
Carruth Center, Inc.	_____	initial to consent
The Parish School	_____	initial to consent

I hereby give permission to The Carruth Center for the following:

_____ In order to process a claim for benefits, I authorize the Carruth Center, to release to my insurance carrier any information regarding my child's medical history, symptoms, treatment, examination results, or diagnosis. Termination of consent must be submitted in writing.

Occupational Therapy REQUIRES Physician's name: _____

Below are listed the person(s), agencies and schools that the assigned individuals or company may contact:

	<u>Name</u>	<u>Address</u>	<u>Telephone #</u>	<u>Fax #</u>
1.	_____			
2.	_____			
3.	_____			

I understand any information obtained is strictly confidential and privileged.

Date

Parent or Legal Guardian

A copy of this instrument is as valid as the original.



THE CARRUTH CENTER
AT THE PARISH SCHOOL

Speech-Language Pathology Services Schedule of Fees

- Speech-Language Consultation (60 minutes without a report) \$100.00
- Speech-Language Consultation (60 minutes with a report) \$130.00
- Speech-Language Evaluation (up to 2 hours with a report) \$350.00
- Individual Session (30 minutes) \$65.00
- Individual Session (45 minutes) \$97.50
- Individual Session (60 minutes) \$130.00
- Group Session (per hour) \$80.00
- Parent Conference (30minutes) \$65.00