Striving for communication success one step at a time

Thank you for choosing Stepping Stones to Speech, LLC to assist in meeting your child's communication needs. I will do my best to guide you through this important process so that it may run smoothly.

The attached is the New Client Intake packet. It includes vital information regarding the scope of my practice, medical insurance, financial and privacy policies. Please fill out the attached forms as best as possible so that I may be well informed of your child's needs.

These packets *must* be completed prior to our first meeting. You may fax the forms to me at 754-223-7061 or email them to steppingstonestospeech@yahoo.com. If your child had any recent speech and language evaluations by another health professional please fax or email me these copies as well.

Please feel free to contact with any questions or concerns regarding this packet.

Best Regards,

Antony Moussignac

Antony Moussignac, MS, CCC-SLP
Speech and Language Pathologist
(wk ph): 954-253-6495
(cell ph): 954-336-1375
(fax): 754-223-7061/
Email: steppingstonestospeech@yahoo.com

# Intake Form

Today's Date: _____

Child's Name:_____ Date of Birth_____

Address:

_____

Medical Diagnosis: _____ School Diagnosis: _____

Parent/Guardian Name: _____ Relationship to Patient: _____

Parent/Guardian Name: _____ Relationship to Patient: _____

Child lives with both parents? Yes No Primary Caregiver _____

Brothers/Sisters:

Name: _____ Age: _____ Grade: _____
Name: _____ Age: _____ Grade: _____
Name: _____ Age: _____ Grade: _____

Email: _____

(H) Phone: _____ (C) Phone: _____ (W) Ph_____

Best way to contact me: (circle all that apply):

(H) Phone (W) Phone (C) Phone Text Email

May we leave a message on your voicemail? (please circle) Yes No

Primary language spoken in the home: _____

Pediatrician:_____ Phone:_____

## REASON FOR REFERRAL

Who referred you to Stepping Stones to Speech, LLC

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What is your main concern about your child's Speech and Language skills?

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When did you first become concerned with your child's Speech and Language skills?

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Please list any previous evaluations (i.e., psychological, IEP, IFSP):

| Name of Practice | Name of Therapist | Date |
|---|---|---|
| | | |
| | | |
| | | |

Has there been a significant change within the last six months? Yes No

If so, what? _____

Does your child display any of the following behaviors such as: (Check all that apply)

____Biting ____Kicking ____ Hitting ____ Spitting _____ Shoving

If yes, does your child display any of these behaviors towards: (Check all that apply)

____Mom ____Dad ____Sister ____Brother ______Pet ______Other _____

## PRENATAL HISTORY

Full term: (Circle) Y N If no, how many weeks_____

Birth weight: ____ lbs ___oz Illnesses during pregnancy: (Circle) Yes No

If yes, please explain: _____

Delivery: (Circle) Vaginal Cesarean Breech

Any use of alcohol, tobacco, medications during pregnancy? (Circle) Yes No

If yes, which one/s_____

Any other conditions affected pregnancy or birth? _____

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## MEDICAL HISTORY

Please list any current medical history (i.e., surgeries, hospitalizations, illness, accidents)

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Please list names and phone numbers of specialists (Occupation, Physical, ABA therapists)

| Specialist Name | Specialty | Phone Number | How many times per week |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Are immunizations current? (Circle) Yes No

Has your child had any ear infections? (Circle) Yes No If yes, please describe

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Does your child have PE tubes? Yes No

Has hearing been tested? Yes No If yes, date? _____ Where?_____

Any hearing concerns? (Circle ) Yes No If yes, please describe

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Does your child have allergies? (Circle) Yes No If yes, describe

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Has your child been evaluated by an Ear Nose and Throat (ENT) doctor? Yes No

If yes, date_____ Reason_____

Is your child taking any medications? (Circle) Yes No Please list:

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## DEVELOPMENTAL HISTORY

Please fill in the months your child achieved each milestone. If your child has not reached the milestone, please state delayed. (If you can't remember exact time, you may approximate)

| Milestone | Age in months |
|---|---|
| Sat alone | |
| Crawled | |
| Walked | |
| Talked | |
| Dressed | |
| Toilet trained | |
| Fed self | |

My child is able to use a: (please circle)

Open cup Spoon Straw

My child has difficulty with: (please circle)

Swallowing Chewing Blowing Drinking

Does your child drool? (please circle) Yes No

Does your child suck his/her finger? (please circle) Yes No

Does your child suck his/her tongue? (please circle) Yes No

## LANGUAGE DEVELOPMENT

What is your child's main form of communication? (check all that apply)

_____Gestures (i.e., pointing, nodding)

_____Vocalizations (i.e., grunting, high pitched sounds)

_____ Words Approximately many? (Circle) 1-5 5-10 10-15 15-20 20 or more

_____ Phrases (i.e., "Up please!")

_____ Sentences (i.e., "I want some please.")

If your child speaks less than ten please list

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Does your child follow directions: (please circle)

1 step 2 step 3 step

Does your child have difficulty understanding you? Yes No If yes, please describe:

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## SOCIAL DEVELOPMENMT

Does your child play with others? Yes No

Does your child have difficulty with separation? Yes No

If yes, how does your child handle separation? _____

How does your child handle frustration?_____

## FAMILY HISTORY

Does your child have family members with any of the following concerns:

| | | |
|---|---|---|
| Speech or Language | Yes No | If yes, who? _____ |
| Stuttering | Yes No | If yes, who? _____ |
| Hearing Loss | Yes No | If yes, who? _____ |
| Autism Spectrum | Yes No | If yes, who? _____ |
| Developmental Delay | Yes No | If yes, who? _____ |
| Reading/Learning Disability | Yes No | If yes, who? _____ |
| ADHD/ADD | Yes No | If yes, who? _____ |

Additional comments or concerns:

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# Consent Form for Treatment

I, _____ hereby attest that I have voluntarily applied for and entered into treatment or give my consent for the minor person under my legal guardianship at Stepping Stones to Speech, LLC. I understand that I may terminate these services at any time.

## Receipt of Policies and Procedures

I hereby attest that I have received a copy of *Stepping Stones to Speech LLC"s Policies and Procedures*, payment and cancellation policies, and have read, understand and consent to be bound by its content.

## Receipt of Consent Form for Photo/Video/Text/Voicemail

I hereby attest that I have reviewed of the *Consent Notice* and understand its content.

## Receipt of Notice of Privacy Policy (HIPPA)

I have reviewed the *Notice of Private Practice under the Health Insurance Accountability Act (HIPPA)* and have accepted the privacy practices, legal duties, and rights concerning my health information. I also understand that the information supplied is required by applicable federal and state law to maintain the privacy of my health information

By signing below, you are attesting to the accuracy of the ale statements including consents and authorizations implied therein. A copy of this agreement is available upon request.

| _____ | _____ | _____ |
|---|---|---|
| Print Name Parent/Guardian | Parent/Guardian Signature | Date |

# Confidential Release of Information

I hereby authorize **Stepping Stones to Speech, LLC** to discuss, obtain or release

information concerning _____ (child's name) to

Antony Moussignac, MS, CCC-SLP.

It is to my understanding that this information will not be shared with any other entity without my prior knowledge. I further acknowledge that the use of this information is to ensure the best quality of care possible for my child.

Please list names of the following people you want to release your information.

| Name | Relationship |
|---|---|
| | |
| | |

_____ _____

Print Name Parent/Guardian Today's Date

_____ _____

Parent/Guardian Signature Relationship to Child

# Consent Form for Photo/Video/Text/Voicemail

In our practice, technology may be a way to communicate with parents. With your permission, a therapist may send you a picture or video your child's session to show progress. Consent is also needed for this to be completed.

I _____give my permission to photo/video my child _____for therapy purposes to show progress.

____ I do not give my permission to photo/video my child for therapy purposes to show progress.

In order to confirm appointments for the week or inform you of results of testing, you give permission to contact you via: Please check all that Apply

Email _____ Text_____ Phone_____ Other_____

If you're not available via phone, I_____ give Stepping Stones to Speech, LLC permission to leave a message via voicemail.

_____ _____

Print Name: Parent/Guardian Today's Date

_____ _____

Parent/Guardian Signature Relationship to Child

# Policies and Financial Agreement Form

Clients are responsible for any and all charges incurred resulting from treatment if insurance provided **Stepping Stones to Speech, LLC, (SSS).** We can only use the information we obtain as an estimated guideline. It is your responsibility to complete all forms required by SSS.

**Parent's Initial _____**

SELF PAY – Payment is due in full at the time services are rendered, unless other arrangements have been made and approved by SSS.

**Parent's Initial _____**

CANCELLATION OF SERVICES POLICY – As part of your financial responsibility, we are advising you that SSS reserves the right to charge a fee for any appointment unless it is cancelled in advance. If your child is unavailable for a scheduled therapy session three times without calling in advance of your appointment, SSS retains the right to discontinue elective treatment and to terminate services. SSS kindly requests that you offer advanced notification so that your therapist is aware of your need to reschedule. At the discretion of SSS, excessive cancellations within a given month may result in a termination of the given contract. If you plan to dismiss your child from therapy, we ask for two weeks notice. Unforeseen circumstances will be dealt with on a case by case basis.

**Parent's Initial _____**

By signing this form you are agreeing to the following: You understand that unresolved financial disputes for non-payment of fees for services rendered could result in the discontinuation of services, referral to another provider as necessary, and assignment of collection responsibility for this account to a professional Collection Agency. Furthermore, you agree that if it should become necessary for SSS to forward your account to a collection agency, you will be responsible for the fee charged by the collection agency for the costs of collection.

**Parent's Initial _____**

I, parent/legal guardian for the child, have been made aware of the billing policies and procedures for Stepping Stones to Speech LLC, and agree to them effective immediately.

| _____ | _____ | _____ |
|---|---|---|
| Print Name Parent/Guardian | Parent/Guardian Signature | Date |

**Stepping Stones to Speech, LLC, reserves the right to make changes to the above policies and procedures at any time.****

## Insurance/Payment Information

### Private Insurance

Insurance Carrier: _____ Policyholder Name:

DOB: _____ ID Number: _____ Group Number: _____

### Medicaid

Medicaid Number: _____ Plan _____

*Please note: Copies of policyholder's driver's license and insurance card may be made at the first appointment.*

### Assignment of Benefits (insurance patients only):

I, _____, authorize the release of any payment and medical information necessary to process me or my family member's insurance claim and related claims. I hereby authorize payment directly to Stepping Stones to Speech, LLC of insurance benefits otherwise payable to me for all professional services.

_____ _____

Signature of Policy Holder Date

### Party Responsible for Payment

Name: _____ DOB: _____ Phone Number: _____

Address: _____

Employer Name: _____ Number: _____

# Consent to Provide Therapy Services at Daycare/School Setting

I, _____ (parent/guardian name) hereby consent for Stepping Stones to Speech, LLC to provide speech therapy services for my child _____(child's name) at his/her daycare/school. It is my responsibility to contact the daycare/school to provide necessary information prior to initial therapy session. We will need a 24 hours notice if your child will be absent from school. COVID 19 Precautions: Please keep your child home if he/she has a fever/ temperature over 99 degrees Fahrenheit. In this event, please keep your child home until they are fever-free for at least 24 hours without medication.

# Consent to Provide Therapy via Teletherapy

Due to the Coronavirus-19 health crisis, teletherapy can be utilized as an option to continue providing speech therapy sessions to your child. Please read the consent information below.

1. I consent to the delivery of speech therapy services by virtual visits over a computer, tablet, or smart phone between Antony Moussignac, SLP and my family/ child. I understand that the availability of virtual visits will depends on the type of technology, devices, or system requirements used.
2. As with any internet-based communication, I understand that risks include the possibility of technological problems which may result in poor quality or disconnection from the virtual visit as well as a security breach without the appropriate computer protections. I understand that Stepping Stones to Speech, LLC is not responsible for my home computer security and acknowledge and knowingly accept the risks of assessing speech therapy services via virtual technology. However, I believe the potential benefits of virtual speech therapy outweigh these risks.
3. I understand that I will not record any teletherapy sessions without prior written consent from Antony Moussignac, SLP.
4. I understand I have the option to withhold or withdraw my consent to the use of virtual speech therapy services at any time. I understand that in home services may be limited or not available due to the current health crisis in Florida Patient Consent to the Use of Teletherapy.

I have read and understand the information provided above regarding teletherapy and I hereby give my informed consent for the use of teletherapy for my child and authorize Antony Moussignac/Stepping Stones to Speech, LLC to use teletherapy in the course of my child's diagnosis and treatment.

| _____ | _____ | _____ |
|---|---|---|
| Print Name Parent/Guardian | Parent/Guardian Signature | Date |

# Policies and Procedures

## Appointments

Currently, therapy sessions are completed at the child's home or school/daycare. If you would like for your child to receive therapy at the daycare/school, you must provide the name, address, phone number and person of contact to me as soon as possible. If I make any changes in date or time for scheduled therapy or need to cancel due to an emergency of my behalf, I will contact you by means of contact as indicated on the Intake Form. **Please make sure you continue to update me with any changes to your address and phone numbers.**

## Cancellations

You **must** give 24 hours in advance to cancel an appointment. If you need to cancel, please do so in advance either by contacting me directly at 954-336-1375 by leaving me a message on my voicemail, sending a text message or email at steppingstonestospeech@yahoo.com . **All appointments cancelled with less than 24 hours notice will be subject to a $50 service fee.** If you arrive late for a session, your child will be seen; however, the appointment may be shortened due to time constraints; the full session fee still applies. This also refers to needing to leave a session in progress early.

## Payment

If you do not have insurance or you no longer carry an insurance policy, I can provide you with a fee payment schedule upon your request. Fees apply to various types of services including direct therapy services, phone consultations, travel and consultations with other professionals.

## Confidentiality

*HIPPA*-This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law.
We will not release any information to anyone unless a signed release is on file.
If you would like a complete notice of HIPPA policies, please let us know.
If you would like to exchange information with persons other than yourself, an Authorization for Release of Information form must be completed. You can request this form at any time.

## Health Policy

Please note that it is important to maintain a healthy environment. A child must be temperature-free or vomit-free for 24 hours before returning to therapy. If your child has a contagious illness such as Strep, Pink Eye, green discharge from nose/eyes, Chicken Pox, Lice, excessive sneezing or coughing, etc.), your child should be under the treatment of a physician when necessary and be receiving appropriate care for at least 24 hours prior to the session. Please use your best judgment.

**Health Insurance**

*Medicaid*

I will check the status of your Medicaid benefits the beginning of each month. If your Medicaid is not active, you will be notified immediately. Please contact *The Department of Children and Families* to reapply for benefits or speak to your caseworker. You may choose to pay privately. You may receive a Fee Payment Schedule upon request. Services will not start until a payment method has been determined.