



Pediatric Registration Form

Today's Date:

Identifying and Family Information

Child's Name:

First Name

Last Name

Address:

Date of Birth:

Home Phone:

Father's Name:

Father's Cell/Email:

Mother's Name:

Mother's Cell/Email:

Siblings/Ages:

School/Grade:

Pediatrician:

Languages Spoken in the Home:

Languages Spoken by Caregivers:

Referral Name (If Applicable):



Medical History

Was there anything unusual about the pregnancy or birth? Yes No

If yes, please explain:

How many weeks was the pregnancy?

Did the child go home with the mother right away? Yes No

If no, please explain:

Has your child had any of following: (please check)

Adenoidectomy	Allergies	Eartubes	Recurrent Ear infections	Encephalitis	
Head injury	Enlarged tonsils	Recurrent Strep	Mumps	Measles	Meningitis
Seizures	Sinusitis	Sleeping difficulties			

Is your child frequently congested? Yes No

Has your child ever been hospitalized? Yes No

If yes, please explain:

Is your child currently taking any medications? Yes No

If yes, please list:



Medical History (Continued)

Has your child been evaluated by any other specialists (e.g., psychologists, occupational or physical therapists, ENTs, etc.)?

Any other health/medical concerns you wish to include?



Developmental History

Provide an approximate age at which your child first:

Crawled	Sat Alone	Stood	Walked	Fed self	Dressed self
Toilet trained	Drank w/ cup	Used single words	Combined words		

Did your child have any feeding issues as an infant? Yes No

If yes, please explain:

Does your child avoid certain textures/consistencies? Yes No

If yes, please explain:

Is your child having difficulty at school? Yes No

If yes, please explain:

Describe your child's personality:



Developmental History (Continued)

What does your child enjoy? Special games, toys, activities or people?

Please provide any other information which may be helpful.



Speech-Language

Describe your child's speech and language skills. What are your concerns?

At what age were concerns about your child's communication skills noted? What were the concerns?

What do you feel is your child's most difficult problem at home? At school?

Has your child had a speech-language evaluation in the past? If so, what were the results?

Has he/she received speech-language therapy? If so, what was he/she working on?

Has your child received any diagnoses (e.g., ADD, Autism, Dyslexia, etc.)?



Orofacial Development

Has your child had any dental concerns? Yes No

If yes, please explain:

Has any orthodontia (braces, expanders, etc.) been recommended or discussed? If so, please explain:

While sleeping does your child: (please check any that apply)

Snore	Break/Pause While Sleeping	Sleep with Mouth Open
Sleep on Stomach	Demonstrate Restless or Agitated Sleep	Bed Wet

Does your child have a history of the following: (please check any that apply)

Thumb-sucking	Finger-sucking	Tongue-sucking	Prolonged Pacifier Use
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Is your child's pillow wet in the morning? Yes No

Does your child keep his/her mouth open while watching TV or using the computer? Yes No

Does your child demonstrate poor posture? Yes No

Does your child drool? Yes No

Does your child eat with his/her mouth open? Yes No

Is your child a messy eater? Yes No

Does your child easily catch colds? Yes No

Does your child clench teeth? Yes No



Fees and Policies

Please sign below that you understand and agree to these policies. Feel free to ask any questions!

- KellerSpeech charges a professional rate of:
 - \$60 per half hour of therapy
 - \$120 per hour of therapy
 - \$240 per hour evaluation
 - \$360 per two-hour evaluation
 - \$300 for oral-habit elimination program
 - \$75 for any progress notes or new treatment plans
- Upon starting therapy, you will be provided with a **treatment plan** outlining the goals for your child's therapy program. This plan is complimentary.
- Currently, KellerSpeech **does not participate with any insurance companies**. Many families choose to submit claims with the documents provided to them (invoices, evaluations, treatment plans, etc.). Please check with your insurance provider for more information.
- We save the **last few minutes** to discuss homework, progress, or to answer any questions. If you feel you need more time, we would be happy to set that up in advance.
- **Brief** emails or calls regarding scheduling/logistical issues are **complimentary**.
- Progress reports or updated treatment plans are **available upon request**.
- Payment is due **once a month**. You will receive an invoice indicating service dates, fees, and the payment due date. If payments are **more than 2 weeks past due**, therapy will be suspended.
- Cancellations happen. We all get sick! We allow for one "free" cancellation every three months. All other missed appointments will be billed at 50% of the session fee. Please try to notify your therapist 24 hours in advance.
- For children who are seen **at home**, it is important that an adult is present in the home during the duration of the session.

Megan Kennedy Keller
KellerSpeech Director/SLP

Date

Parent

Date



Release of Information

Date:

KellerSpeech LLC is hereby given permission to share information regarding:

- with the following individuals

or agencies:

Signature

Date

I have received a copy of KellerSpeech's HIPPA privacy practices:

Signature

Date



HIPAA Notice of Privacy Practices THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Who Will Follow This Notice This joint notice applies to our staff, business associates and therapists while they are treating you. It describes how we will use and share your information, how we are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information (PHI). PHI is information about you, including demographic information, that may identify you and that relates to your health or condition and related health care services. We are required to abide by the terms of the notice currently in effect. If you have questions about any part of this notice or if you want more information about our privacy practices, please contact our HIPAA Compliance Officer at (571) 332-6603.

I. How we may use or share your health information. We are committed to protecting the privacy of your health information. The law permits us to use or share your health information for the following purposes:

- 1. Treatment.** We may use or share your PHI with physicians, nurses, and other health care personnel who provide you with health care services or are involved in your care. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.
- 2. Payment.** We may use or share your PHI to obtain payment for your health care services. For example, obtaining approval for payment of services from your health plan may require that your PHI be shared with your health plan. We may also provide your PHI to our business associates, such as billing companies.
- 3. Health Care Operations.** We may use or share your PHI in order to operate our facilities. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to accountants, attorneys, consultants, and others in order to make sure we're complying with the laws that affect us.
- 4. Notification and Communication with Family.** We may release your PHI to a relative, close friend, or any other person you identify, information that directly relates to that person's involvement in your health care unless you object. If you are unable to agree or object to the release, we may release information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or release PHI to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care to tell them your location or general condition. Finally, we may use or share your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and releases to family or other individuals involved in your health care.
- 5. Required by law, court, or law enforcement.** We may release PHI when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with crime; or when ordered by a court.
- 6. Public Health.** As required by law, we may release PHI to public health authorities for purposes related to preventing or controlling disease, injury or disability; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.
- 7. Research.** We may release your health information to researchers conducting research that has been approved by an Institutional Review Board.
- 8. Specific Government Functions.** We may share your health information for military or national security purposes.
- 9. Appointment Reminders & Health Related Benefits.** We may use your PHI to contact you to provide appointment reminders or to give information about other treatments or health-related benefits and services that may be of interest to you.
- 10. Diagnostic and therapeutic information regarding psychiatric, drug/alcohol abuse, or sexually transmitted diseases (including HIV status) will not be disclosed without your specific permission, unless required by law.**

II. Your Health Information Rights

- 1. You have the right to request a limit on certain uses and releases of your health information.** We will consider your request but are not required to accept it. These requests must be in writing and submitted to our HIPAA Compliance Officer.
- 2. You have the right to choose how you receive your health information.** You have the right to ask that we send information to you at an alternative address or by other means (for example, telephone instead of mail, post office box instead of home address). We must agree to your request so long as we can easily provide it in the format you requested. These requests must be in writing.
- 3. You have the right to see and get copies of your health information, in most cases.** These requests must be in writing.
- 4. You have a right to request that we correct or update information that is incorrect or incomplete.** We are not required to change your health information. If we deny your request, we will provide you with information about our denial and how you can disagree with the denial. These requests must be in writing.
- 5. You have a right to receive a list of disclosures we have made** except that we do not have to account for the disclosures described under treatment, payment, health care operations; information provided to you; information released based on your written authorization; directory listings; certain government functions; disclosures of a limited data set (which may only include date information and limited address information); and to correctional institutions or law enforcement in custodial situations. These requests must be in writing and must state a time period.
- 6. You have a right to get a paper copy of this Notice of Privacy Practices.** You may request a copy of this notice at any time.

III. Changes to this Notice of Privacy Practices

We reserve the right to change this Notice of Privacy Practices at any time in the future. We reserve the right to make the changed notice effective for health information we already have about you as well as any we receive in the future. We will post a current copy of the Notice. Upon request, you may obtain a copy of the current notice by contacting our HIPAA Compliance Officer at (571) 332-6603.

IV. When We May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, we will not use or disclose your health information without your written authorization. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

V. Complaints

If you believe your privacy rights have been violated, you may file a complaint with our HIPAA Compliance Officer or with the Secretary of the Department of Health & Human Services. To file a complaint with our HIPAA Compliance Officer, call (571) 332-6603. You will not be penalized for filing a complaint.