Making a difference together

Dear Parent/Guardian:

Esperanza Children's Therapy is delighted to become part of this community's health network. We aim to provide exemplary occupational/sensory processing activities, physical, speech and language therapy for children ages three to eighteen within a clinical setting.

In order to successfully begin the application process we ask that you provide the following documentation:

- Primary Care Physician prescription including: child's name, date of birth, diagnosis, ICD-10 Code, type of therapy specifying that prescription is valid for evaluation and therapeutic services
- Copy of Insurance Card
- Copy of existing child's Individualized Education Plan (IEP) or Individual Family Service Plan (IFSP)

If you have any questions please feel free to contact our clinic manager at

1681 Hickory Loop,
Las Cruces, NM 88005
Tel: 575-647-3773
Fax: 575-647-3777

INTAKE FORM

General Information: **Date: ___________________**

Name of Person Completing This Form: __________________ Relation to Child__________________
Child's Name:____
Date of Birth: ___________ Sex: Male □ Female □
Is your child adopted? Yes □ No □ Is this child in foster care placement? Yes □ No □
Student lives with: _____both parents _____mother _____father _____other (describe):
____
Mother's Name: _______________________________ Occupation: ___________________________
Father's Name: ________________________________ Occupation: ___________________________
Legal Guardian: _______________________________ Occupation: ___________________________
Other Caregivers: ____

People living in the household:

Name	Relationship to Child	Age

- Are there any brothers or sisters not living at home? Please list name and age:
____

Current General Concerns about the Child

What concerns do you have about your child at home and school?
____
____

What are your child's strengths (things he/she can do very well)? ___________________________
____

What are your child's areas of needs (things he/she needs help with)?
____
____

↳ **Please check any areas of concern:**

- ☐ **Language** – *understanding information, vocabulary, sentence structure, grammar*
- ☐ **Articulation** – *how your child says his/her speech sounds*
- ☐ **Fluency** – *how smoothly your child's word flow when he/she speaks*
- ☐ **Voice** – *how your child's voice sounds (hoarse, breathy, raspy, etc.)*
- ☐ **Feeding** – (i.e., drinks from a regular cup and straw, eats regular solids or needs to have foods finely chopped, picky eater)
- ☐ **Fine Motor** (i.e. coordination with small objects, fastening clothing, using both hands together, picking up small objects)
- ☐ **Gross motor** (i.e., coordination of large movements, balance, ball skills, accessing playground equipment, walking)
- ☐ **Sensory Processing** (i.e. self-regulation, responses to touch, movement, other sensations, planning and performing movement skills)
- ☐ **Activities of Daily Living** (i.e., dressing, eating, washing hands, chores)

* Describe concerns here ____

____

____

Child's Educational Information:

Check if your child has attended or received services at one of the following:

☐ Preschool	☐ Private School	☐ Other ______________
☐ Head Start	☐ Day Care	
☐ Home School	☐ Agency (*Aprendamos, MECA, etc.*)	

School Attended	Grade	Progress	Special Education Services (IEP, SLP, OT, PT)

Have other adults or children in the family had special needs or difficulties in school (i.e., communication, learning or behavior)?

____

Pregnancy, Birth, Early Development *(Parents/Guardians have the right not to disclose medical information.)*

Yes	No		Yes	No	
_____	_____	Normal full term pregnancy	_____	_____	Over due birth
_____	_____	Complications during pregnancy	_____	_____	Difficulty breathing
_____	_____	Premature birth	_____	_____	Difficulty sucking
_____	_____	Caesarian birth	_____	_____	Difficulty responding to touch
_____	_____	Difficult labor and/or delivery	_____	_____	Other (*describe*)___________

Weight at birth: _________ lbs., _______ oz. Hospital's name/place __________________

Illnesses during pregnancy:
_____ Infections _____ Pre-eclampsia _____ Hypertension _____ Fevers
_____ Gestational Diabetes _____ Other ____

Were any of the following used during pregnancy?
☐ Prescription drugs or medications – list ____
☐ Alcohol
☐ Recreational drugs
☐ Tobacco

Please explain or add comments about pregnancy, birth, and development
____
____

Speech/Language & Motor Development - Developmental Milestones

	(Circle One)			Age
Sat alone	early	average	late	__________
Crawled on hands and knees........	early	average	late	__________
Said first word	early	average	late	__________
First fed him/her self	early	average	late	__________
Walked independently	early	average	late	__________
Said first sentence	early	average	late	__________
Dressed him/her self alone	early	average	late	__________
Tied shoes	early	average	late	__________
Buttoned shirt	early	average	late	__________
Toilet trained	early	average	late	__________
Generally, development was	early	average	late	__________
Hand preference	right	left	neither	__________

	Yes	No
Does your child use any special equipment such as braces, wheelchair, communication device (AAC), etc.? (*Please describe*)____________________ ____	____	____
Does your child have sensitivities to touch/sound/movement/vision? (*Please describe*)____	____	____
Are your child's communication skills similar to those of siblings/friends?	____	____
Does your child have any habits/behaviors different from other children? (If yes, *please describe*)____	____	____

Medical History and Concerns

Describe your child's current health status ____
____
____

Does your child have any chronic health problems (e.g. allergies, heart condition)?
Explain:____
Does your child have a medical diagnosis? ____
Is your child currently taking any medications?____
Current Physicians/Specialists following your child (e.g. orthopedist, neurologist, ENT, gastroenterologist):________________________________

Has your child been diagnosed with and/or experienced any of the following:

Syndromes	√ If Yes	Multiple Congenital Anomalies	√ If Yes	Other Illness or Conditions	√ If Yes
Down Syndrome		CHARGE Syndrome		Anemia	
Trisomy 13		Fetal Alcohol Syndrome		Bleeding Problems	
Usher		Hydrocephaly		Diabetes	
Other Syndrome (*list*)		Maternal Drug Use		Heart Disease/Condition	
		Microcephaly		High Blood Pressure	
Postnatal (after birth)		Other Multiple Anomaly		Loss of Consciousness	
Asphyxia		Other Illness or Conditions		Extreme Tiredness	
Encephalitis		High Fever		Paralysis	
Head Injury		Convulsions		Bone or Joint Disease	
Meningitis		Seizures		Eating Problems	
Stroke		Scarlet Fever		Sleeping Problems	
Other Postnatal		Rheumatic Fever		Eye Problems	
Prenatal Dysfunctions (before birth exposures)		Tuberculosis		Memory Problems	
Herpes		Frequent/Severe Headaches		Ear Infections	
Rubella		Dizziness		Tubes in Ears	
Syphilis		Fainting Spells		Allergies	
Toxoplasmosis		Cancer			
Other Prenatal Condition		Asthma			

Additional comments or explanations ____
____
____

Child's Daily Life with Family

What favorite interests, skills or hobbies does your child enjoy?________________________________
____

What are your child's responsibilities at home? ____

Language Dominance of the Child

What language(s) does your child speak?____
In what languages does your child: Speak at home? ____________ Watch TV? ____________
Sing/listen to music? _________ Read & Write? _______

When did your child begin to learn a second language? _____________________________

Other important information about your child: _______________________________________
_______________ ____

Signature of person providing information: __________________________________ Date: ________________

Office Signature: ___________________________ Date: ____________________________

Consent Agreement

Patient Name: ____________________________ **Date of Birth:** ____________________________

Esperanza Children's Therapy Group would like to thank you for selecting us to be part of your child's growth and development.

CONSENT FOR SERVICES

Having been advised of my child's rights, given and provided with an opportunity to ask questions, I hereby consent and authorize **Esperanza Children's Therapy** to provide care and treatment to my child in the Esperanza Children's Therapy Clinic per program policy and/or physician prescription. I hereby consent to **Esperanza Children's Therapy** to provide services that include: Physical Therapy, Occupational Therapy, and/or Speech Therapy services authorized and ordered by my child's physician. My child's treatment plan of care has been explained to be and all my questions have been addressed and answered. If at any time my child's treatment plan of care changes, these changes will be discussed with me. I agree to continue under the care of my child's physician and to notify my child's physician of any significant events/changes relating to my child's health.

If I become unable to make decisions or sign documents for my child regarding services due to incapacity or disability during the course of my child's treatment; I hereby authorize the person indicated below to act on my behalf regarding all matters relating to my child's therapy services.

AUTHORIZED PERSON TO ACT ON MY CHILD'S BEHALF:	**PHONE #**:	**ADDRESS:**
EMERGENCY CONTACT:	**PHONE #**:	**ADDRESS:**

RELEASE OF INFORMATION

I consent to/authorize **Esperanza Children's Therapy Group** to release relevant information contained in my child's confidential clinical record to health care providers involved in my child's care and to third party payers, utilization review and professional standard review organizations, regulatory review entities and any other professional organizations, companies, community resources, etc. that may/will assist my child to meet his/her needs. My written consent will be required for release of my child's medical information to those not authorized to receive it. I have received the Privacy Notice outlining the agency privacy practices per HIPAA federal regulation.

____________________________________ ______________________
Primary Care Physician Telephone

____________________________________ ______________________
Referring Agency Telephone

____________________________________ ______________________
Other Telephone

CONSENT TO TREAT

_____ **(Initials)** I authorize the staff of **Esperanza Children's Therapy Group** to (1.) administer/perform those treatments that have been prescribed by my child's physician; (2.) to release pertinent medical information to my child's physician, employer (relevant if parent's employer), referring agency, or insurer and others as may be required; and (3.) to obtain/request medical information from physician and other health care professionals as required.

PHOTOGRAPHY AND VIDEO TAPE RELEASE FORM

_____ **(Initials)** I give consent to Esperanza Children's Therapy employees to take photographs and or video tape of my child during therapy sessions. I understand that these photographs and/or video tapes may be used for any lawful purpose including but not exclusive to educational/treatment during the period of time while receiving services at Esperanza Children's Therapy. I consent and understand that pictures of my child may be posted on bulletins within the clinic facilities.

HIPPA/ NOTICE OF PRIVACY PRACTICES

______ **(Initials)** The HIPAA agreement states that you must be given the HIPPA information to parents and the Notice of Privacy Practices statement developed by Esperanza Children's Therapy Group. The notice states how Esperanza Children's Therapy Group can use the information from your child's personal file and when and who they can give the information to.

NON-COMPLIANCE POLICY

______ **(Initials)** I understand and agree with **Esperanza Children's Therapy Group** non-compliance policy, which states that if a therapy appointment needs to be canceled or rescheduled I must contact the **Esperanza Children's Therapy Clinic** main office 24 hours prior to the scheduled visit. Failure to cancel 24 hours prior to the appointment will result as a no show on my child's file. I will not contact the therapist directly to change my child's therapy schedule. I also understand that if my child fails to meet regularly scheduled therapy sessions on a continuous basis, his/her therapy services will be placed hold with the possibility of termination of services. Initial evaluations will be rescheduled a maximum of three times if failure to appear at the scheduled appointment times.

TEACHING FACILITY

______ **(Initials)** I understand that Esperanza Children's Therapy is part of Aprendamos Intervention Team. Aprendamos Intervention Team and Esperanza Children's Therapy are in agreement with local Universities to allow students to complete their field practicum. I give my consent for Aprendamos Intervention Team students and/or employees to observe and/or work with my child under the guidance of the licensed therapist.

REMAINING ON PREMISES

______ **(Initials)** I understand that I am not to leave the clinic during my child's therapy session. If an emergency arises, the Esperanza staff will need to have a parent/caregiver present to assist.

FINANCIAL AGREEMENT AND OBLIGATION

______ **(Initials)** I certify that all information given by me to **Esperanza Children's Therapy Group** is correct to the best of my knowledge. I authorize Medicaid/Private Insurance/Other to pay any and all applicable benefits directly to **Esperanza Children's Therapy Group.** I understand that I am financially responsible for all charges not covered by Medicaid/Private /Other insurance. *****I understand that if I do not provide the Esperanza front office staff with documentation of a new insurance or change in insurance, then I will be liable for all charges not covered.*****

If at any time I wish to revoke any of the above mentioned permission, I can do so by providing Esperanza Children's Therapy with the request in writing.

_______________________________ _____________________

Parent/Guardian Signature Date

_______________________________ _____________________

Esperanza Children's Therapy Group Date

Patient Name: ________________________ **Date of Birth:** _______________

Service Agreement

Esperanza Children's Therapy is an outpatient facility that provides Physical, Speech, and Occupational therapy services under the guidance of a physician. Services are stipulated on a Plan of Care that is created by the licensed therapist upon completing an Evaluation Report. Services will be provided by a licensed therapist and/or by an assistant under the supervision of a licensed therapist at **Esperanza Children's Therapy**.

Acknowledgments:

- **Esperanza Children's Therapy** will service my child without regard to race, color, sex, religion, age, national origin, or handicap.
- I understand **Esperanza Children's Therapy** responsibilities to report all possible neglect and abuse to the appropriate agency.
- I understand that **Esperanza Children's Therapy** cancellation policy indicates that I will call 24 hours in advance in order for the visit to be considered a cancellation. In the case that we cancel or no show 3 times within a month time frame my child may be discharged from services due to non-compliance with visits.
- I will make up visits when cancelled within the month in order for my child to follow his Plan of Care.
- I understand that **Esperanza Children's Therapy** personnel cannot transport patients/clients for any reason.
- I understand that I must remain in the building while **Esperanza Children's Therapy** is providing therapy services.
- I have been informed verbally and in writing in advance about the charges for services or items that I may have to pay for rendered services by **Esperanza Children's Therapy.**
- I understand that if at any time I change insurance plans or provider, I am to notify **Esperanza Children's Therapy** immediately. I understand that I am responsible for any charges not covered by my insurance due to failure in notifying changes.
- I participated in my child's plan of care to include, but not limited to, the following services and frequencies.

The time frame indicated below has been approved by your child's insurance carrier for services. Please remain within the time frame in order to ensure that your child has access to all visits initially approved. The authorization does not guarantee payment of services but is necessary to initiate treatment. Additional visits as requested and recommended by the therapist may or may not be authorized by the insurance carrier.

Speech: Visits: _____ at _____ per week from ____________ to ____________.
Occupational: Visits: _____ at _____ per week from ____________ to ____________.
Physical: Visits: _____ at _____ per week from ____________ to ____________.

I have received a copy of this Service Agreement. I understand that I may direct further questions regarding services by calling 575-647-3773. If you have a problem or complaint, please do not hesitate to contact **Esperanza Children's Therapy** Director Celina Waller.

________________________________ ____________________

Parent/Guardian's Signature Date

________________________________ ____________________

Office Signature Date

HIPPA Information to Parents

HIPAA is the Health Insurance Portability and Accountability Act (HIPAA). It was put into place to protect and ensure privacy of all accumulated health information about the child. It was signed into law in 1996 under the United States Department of Health and Human Services. Healthcare and other service providers nationwide were required to comply with the rules and regulations of privacy protection by April of 2003.

What does it mean?
It means that your child's private health information (PHI) is protected by federal law. You have rights regarding your child's PHI and it provides specific rules and regulations on who may have access to it.

Why do I have to sign the HIPAA agreement?
The HIPAA agreement states that you must be given the "Notice of Privacy Practices" statement developed by **Esperanza Children's Therapy Group**.

The notice states how **Esperanza Children's Therapy Group** can use the information from your child's personal file and when and who they can give the information to.

Once you start receiving service from **Esperanza Children's Therapy Group** program you only have to sign the HIPAA paperwork once and then it will become part of your child's file.

What are my rights under the federal HIPAA laws?
You can ask to see your child's records and to get copies of them. You can have any corrections that you feel need to be made, including in your child's chart.

You will be notified if your child's health information needs to be shared with health care professionals, evaluation team, therapists, with other providers, or billing personnel.

You can file complaints if you feel your privacy rights were violated in any way. You will not be penalized for filling a complaint.

What kind of information does it protect?
It protects any kind of health information such as visits, evaluation and assessments, treatment, and consultation.

This includes mental health information, therapy, counseling or other aspects of mental health care. Information that is spoken, printed, or transmitted electronically all fall under the HIPAA privacy act.

Does Esperanza Children's Therapy Group have the right to share my information?
Yes. **Esperanza Children's Therapy Group** does have the right to share your information with:

- For coordination of the services
- To report any information that affects your child's or your families welfare, and
- With any family, friends or other people that YOU determine as acceptable.

Keep in mind that if you want your child's records from **Esperanza Children's Therapy Group** sent to another agency, you will have to sign the Consent to Release Information form.

What if I want access to my child's record?
You should be able to have access to your child's information whenever you want. You also have the right to know who your information has been shared with.

Who gets to see my confidential health information?

Anyone directly involved in your child's service plan would have access to your information. Basically anyone who is necessary to provide the best services that your child and your family can receive, as stated on the Release of Confidential Information form.

If you need more information about HIPAA, please contact (575) 647-3773.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
Please review it carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

Federal and state law requires us to maintain the privacy of your health information. That law also requires us to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices we describe in this notice while it is in effect.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that your health information is personal. We are committed to protecting this information.
We create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements.
This notice will tell you about the ways in which we may use and disclose your health information. We also describe your rights and certain obligations we have regarding the use and disclosure of health information. We are required by law to: make sure that your health information is kept private; give you this notice of our legal duties and privacy practices; and follow the terms and notice that is currently in effect.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

Treatment: We may use your health information to provide you with medical treatment or services. We may disclose this information to doctors, nurses, technicians, medical students, or other personnel who are involved in providing therapy services. We may also disclose medical information about you to people outside the health system who may be involved in your medical treatment. For example, a doctor treating you for a broken leg may need to know what therapy services you are currently receiving.

Payment: We may use and disclose your health information so that the treatment and services you receive from **Esperanza Children's Therapy Group** may be billed to, and payment may be collected from Medicaid or other such insurance.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating therapists and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations.

Individuals Involved In Your Care or Payment for Your Care: We may release medical information about you to a family member or other designated person who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an agency assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit.

- As required by law;
- For public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- To report adult abuse, neglect, exploitation, or domestic violence;
- To health oversight agencies;
- In response to court and administrative orders and other lawful processes;
- To law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person:
- To coroners, medical examiners, and funeral directors;
- To an organ procurement organization;
- To avert a serious threat to health or safety

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may request access by sending us a letter to the address at the end of this notice. If you request copies, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

Disclosure Accounting: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you that are not related to treatment, payment, or health care operations, and for which we were not required to obtain your authorization. You must submit your request in writing and must include the calendar dates you want to see. The time period cannot include more than 6 years of information, and cannot begin prior to July 13, 2006, and indicate what form you want the list (paper copy or electronic). There will be no charge for the first list you request within a 12 month period. We may charge you for the costs of providing any additional lists. We will notify you of the cost involved. You may choose to withdraw or modify your request at that time before any costs are incurred.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to the additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (contact you only at work or by mail). You must make your request in writing. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why we should amend the information. We may deny your request under certain circumstances.

Changes to This Notice: We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. Current copies of this notice will be available at the address listed below.

The effective date of the notice will be posted on the first page, in the top right-hand corner.

Complaints: If you believe your privacy rights have been violated, you may file a complaint by contacting the U.S. Department of Health and Human Services. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

If you have any questions about this notice, please contact the Director at (575) 647-3773.

Health Insurance

Patient Name: ________________________Date of Birth: __________________

Policy Number:

- ☐ Blue Cross Blue Shield: _____________________________________
- ☐ Lovelace Health Plan: _______________________________________
- ☐ Presbyterian Health Plan: ___________________________________
- ☐ United Health Plan: ____
- ☐ Humana: ____
- ☐ Aetna: ____
- ☐ Other: ____
  - ☐ Deductible: $______
  - ☐ Co-Pay: $______
  - ☐ Co-Insurance: ______%

I understand that under my health insurance plan a deductible, co-pay or co-insurance may be applicable to my policy. I acknowledge being financially responsible for any charges/claims submitted not covered by my health insurance policy. If there are any changes in my health insurance plan, I will notify Esperanza Children's Therapy before the effective date of any insurance changes as this may affect coverage.

Parent Name: ____

Parent Signature: ____

Responsible Party's Social Security Number: ____________________________________

Date: ____

Consent to Release and Share Information

I/We,____,
Parent/Legal Guardian Name(s)

give my/our informed consent for: Esperanza Children's Therapy, Aprendamos Intervention Team and Mariposa Autism Service Center to obtain records, communicate and share information in writing and conversation with:

____
Provider/ Agency (if applicable)

____
Street Address/Post Office Phone

____
City/Town State Zip Code

Regarding:

____
Child's Legal Name DOB

____
Street Address/Post Office

____
City/Town State Zip Code

____
Telephone

_____ Medical _____ Insurance _____Therapy _____School _____Other_______________

I have read and understand the condition of this release. This consent is valid for time frame while in treatment with Esperanza Children's Therapy. I may choose to revoke this consent by notifying Esperanza Children's Therapy in writing.

____ __________________________
Signature (parent/legal guardian/educational surrogate) Date

____ __________________________
Office Signature Date

Form used for: Obtaining and sharing information

This form meets all applicable regulations for theFamily Educational Rights and Privacy Act (FERPA)and the Health Information Privacy and Portability Act (HIPPA).

Patient Last Name: ________________ **First Name:**______________ **MI:**___ **DOB:**___________

The listed parents and guardians may obtain information pertaining to the treatment/therapeutic services of the above mentioned patient whom is receiving services at Esperanza Children's Therapy.

Mother Last Name: __________________________ First Name: ___________________________
Address: ____________________________City_________ State _____ Zip: _________________
Home Phone: ________________ Cell Phone: ________________ Work Phone: _______________

Father Last Name: ___________________________ First Name: ___________________________
Address: ____________________________City_________ State _____ Zip: _________________
Home Phone: ________________ Cell Phone: ________________ Work Phone: _______________

Guardian Last Name: ________________________ First Name: ___________________________
Address: ____________________________City_________ State _____ Zip: _________________
Home Phone: ________________ Cell Phone: ________________ Work Phone: _______________

Primary Insurance

Insurance Company: __________________________________ Phone:_______________
Effective Date: ________________
Policy #: __________________________ Group Name/Number: ____________________________
Name of Insured: _____________________________ Insured Date of Birth: _________________
Insured's Employer: _______________________Insured Social Security No.:____________________

Secondary Insurance

Insurance Company: __________________________________ Phone:_______________
Policy #: __________________________ Group Name/Number: ____________________________
Effective Date: ________________
Name of Insured: _____________________________ Insured Date of Birth: _________________
Insured's Employer: _______________________Insured Social Security No.:____________________

Current Medical Information (List any medications, physicians/specialists, evaluations completed,etc):____
____
____

Current Concerns:
____
____

All Professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments, however, the patient is responsible for all fees regardless of insurance coverage. It is customary to pay for services when rendered.

Parent Signature: ______________________________________ Date: ____________________

Office Signature: _______________________________________ Date: ____________________

Hearing Screening Consent

Patient Name: _________________________ Date of Birth:_____________________

I/We,____,
Parent/Legal Guardian Name(s)

give my/our informed consent in order for Esperanza Children's Therapy to complete a Hearing Screening.

- The Hearing Screening will be attempted at the time of the initial evaluation or during the first treatment session to include:
    - Otoacoustic Emissions (OAE)- A screening which measures the inner ear's ability to hear Sounds.
    - Tympanogram: a screening which tests the mobility of the ear drum and the middle parts of the ear.
- The Hearing Screening is **NOT** intended to provide a diagnosis. It is to screen for possible cochlear hearing loss and/or middle ear hearing dysfunctions.
- I understand that the Hearing Screening will provide a "pass or refer" result.
- It is my responsibility to follow up with my child's primary care physician if the screening result indicates "Refer".
- Hearing Screening results will be provided to my child's primary care physician.

_____ (Parent Initials) I accept for a hearing screening to be performed

_____ (Parent Initials) I decline the hearing screening

____ __________________________
Signature (parent/legal guardian/educational surrogate) Date

____ __________________________
Speech Language Pathologist Signature Date