STEPPING STONES THERAPY, LLC
OCCUPATIONAL & SPEECH/LANGUAGE THERAPY

4300 Montgomery Ave.
Suite 303
Bethesda, MD 20814
301-652-7800
Fax 301-652-0622
www.steppingstonestherapy.com

Child's Name: _____

Date of Birth: _____

Parent's Name: _____

Home Address: _____

City: _____

State & Zip: _____

Home Phone: _____

Cell Phone: _____

Business Phone: _____

Email Address: _____

(Bills will be emailed unless otherwise specified)

Person Responsible For Account: _____

Referred By: _____

Pediatrician or Referring Dr.: _____

Child's School: _____

Allergies or Special Diet: _____

If you would like to have your credit card automatically billed each month, please fill in the information below:

Name on Card: _____

Card Number: _____

Expiration: _____

Circle One: **Visa** **MasterCard**

Check here for auto charge _____

Please describe your concerns about your child's speech and language development.

When did you become concerned about your child's speech and language development?

How does your child usually communicate? Have any other speech and language specialists seen your child? If so, what were their conclusions?

Has the child had a hearing test? By whom? What were the results?

Does your child have any difficulty walking, running or participating in activities that require small or large muscle movements?

How does your child respond to directions that you give to him or her? Do they need you to repeat yourself or can they typically follow on the first try?

Has your child ever been given a medical diagnosis? _____ If yes, what diagnosis?

What was the treatment?

Were there any complications (e.g., maternal health problems, bed-rest, medications) with the pregnancy? _____ Explain.

Was the mother on bed rest and if so, for how long?

Was your child born premature? _____ Please provide details as to difficulties and treatment.

Were there any complications during labor and/or delivery (e.g., forceps, vacuum extraction)? Explain.

Apgar scores:

Child's birth weight:

Was your child admitted to the NICU? _____ If so, explain (include length of stay).

Was your child nursed? _____ If so, until what age?

Was there anything remarkable about your child's early feeding history?

Has your child ever suffered from ear infections?

If yes, how many?

Which ears?

At what age(s)?

Were PE tubes inserted? If yes, at what age?

Does your child have fluid in his/her ears?

If yes, for how long?

Is your child sensitive to certain sounds/pitches (e.g., vacuum cleaners, blenders)?

Does your child cover his/her ears when he/she hears certain sounds? (specify)

Does your child seem under-reactive to loud sounds (e.g., ambulance)?

Is your child on any medications? (specify)

Does your child have any allergies? (specify)

Did your child ever suffer from reflux?

Were any medications prescribed?

Explain your child's typical eating habits:

Does your child crave food? If yes, please list:

Does your child have any food allergies? _____yes _____no _____never tested. If yes, describe.

When eating, does your child prefer specific textures (e.g., mushy, crunch), tastes (e.g., sour, sweet, bland) or temperatures (e.g., hot, cold)?

Please provide examples of regularly consumed foods that are:

Mushy _____ Crunchy _____

Chewy _____ Sour _____

Sweet _____ Bland _____

Cold _____ Hot _____

Please describe a typical breakfast.

Please describe a typical lunch.

Please describe a typical dinner.

Please describe typical snacks.

Does your child drink from an open cup?

Use a straw?

Does your child use a pacifier?

At what age did he/she stop?

Does your child suck his/her thumb?

At what age did he/she stop?

Does your child eat from a fork?

Spoon?

Does your child feed him/herself with a fork?

Does your child put toys and fingers in his mouth?

Does your child drool?

Can your child blow bubbles?

Can your child blow whistles?

What languages are spoken in the home or in any of your child's other settings?

Does your child communicate with gestures?

Sounds (e.g., grunts)?

At what age did your child begin using one-word utterances?

Two-word utterances?

Give examples of several phrases your child often uses (e.g., "want milk")

Do others understand your child when he/she communicates?

Do you understand your child when he/she communicates?

Is your child showing signs of frustration arising from his/her communication?

At what age did your child begin to crawl?

To walk?

Describe your child's crawl.

Does your child interact well with peers?

With adults?

Does your child make eye contact with others?

List other professionals working with (or who have worked with) your child:

Names/Professions:

Phone Numbers:

Does your child attend school, day-care, or other program? (specify name, days attended, and length of day).

Describe the child's current activity level (low, typical, high).

What is the child's current sleep pattern? Sleeps from _____ to _____.
Naps from _____ to _____ .

What activities does your child enjoy the most?

What activities does your child refuse to do?

How does your child spend most of his/her time?

How much time does your child spend watching television/iPad/smart phones/computers per day?

Does your child have difficulty calming him/herself?

Does your child respond to his/her caregiver with a facial expression, gesture, or vocalization?

Does your child show back-and-forth communication (e.g., gesture, facial expression, or verbalization) with his/her caregiver? For example, mom smiles at child, child coos, then mom coos and child reaches to be picked up, then mom smiles and then baby laughs.

Which of the following concern you? (check all that apply)
1) number of words your child uses in a sentence
2) your child's pronunciation of words
3) your child's ability to understand language
4) your child's play/social skills
5) your child's eating habits
6) your child's ability to maintain attention
7) your child's ability to read
8) your child's ability to use language to converse (back-and-forth dialogue) Please explain.

Does your child repeat a word or sound within an utterance (e.g., “like like like this one mom”)?

How many times does your child repeat the repeated sound or word?
Two or less?
Three or more?

How many times a day does your child repeat a word or sound within an utterance?

Is your child repeating sounds, syllables, or words? (Provide examples).

How long has your child been repeating sounds, syllables, or words? (Provide approximate dates).

Is your child left-handed or right-handed?

What do you hope therapy will accomplish?

Who will implement a speech and language home program?

Who recommended that you see a speech-language pathologist?

How did you hear about Stepping Stones Therapy?

Have other family members been treated by a speech-language pathologist?

If so, why?

Have any immediate family members been diagnosed with autism?

Have any extended family members been diagnosed with autism?

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POLICIES & PROCEDURES

Stepping Stones Therapy, LLC is pleased to have you as a valued family in our practice. We offer a full range of Occupational Therapy and Speech and Language Therapy services for your child including the assessment and treatment of speech and language and sensorimotor as well as any support services you may need with your child's school or home programming.

- **Treatment Sessions:** Therapy sessions are **55 minutes** in length unless you have made other arrangements with your therapist. Please feel free to ask brief questions at the end of the treatment session, reserving more lengthy discussions for consultation appointments. While we do not require you remain present in our office during sessions, it is imperative that you **return to the office on time**, as therapists see students back to back.
  _____(initial here)

- **Fee Schedule:**
  - Individual Speech and Language and Occupational Therapy sessions - $140 per 55 minutes
  - Group Speech and Language and Occupational Therapy sessions - $120 per 55 minutes
  - School visits - $140 per 45 minutes
  - Speech and Language and Occupational Therapy Evaluations - $350 (this includes testing time and a brief summary of scores)
  - Full written report - $275
  - Articulation/Oral Motor Evaluations - $140
  - Group Screenings - $35

  _____(initial here)

- **Insurance Paperwork**: Any requests for information to your insurance company will be billed at a flat rate of **$40**. We will notify you if we receive a request from your insurance company.
  _____(initial here)

- **Billing:** Your child's bill will be issued on the last therapy session of each month. We will email your child's bill in PDF form, unless otherwise specified. **We require that you keep a credit or debit card on file with our office (please fill out the attached form)**. **Any balance that is not paid in full by check by the 15th of the month will automatically be billed to the credit/debit card on file.**
  _____(initial here)

- **If your account becomes more than 90 overdue, we reserve the right to discontinue services indefinitely.**
  _____(initial here)

- Please be advised that if you are being reimbursed from your insurance company for services rendered, your payment is still due to Stepping Stones on the 15th of the month.
  _____(initial here)

- **Cancellations:** If you must cancel a session, please call your child's therapist no later than **7am on the day of the session**. **You will be billed $140 for sessions that are not cancelled by 7am.** Please contact your therapist directly to cancel sessions. If frequent cancellations become problematic, we reserve the right to bill for a minimum of three sessions per month in order to hold your time slot.
  _____(initial here)

- **School Visits**: School visits will be billed at $140 for 45-minute session. **It is the parent's responsibility to inform your therapist if your child will not be in school for the any reasons including**: out sick, school closings, half days or field trips. You will be billed $140 for school visits that are not cancelled by 7am.
  _____(initial here)

- **Privacy guidelines:** Your child's therapy session will be discussed with you in the waiting room at the end of each session.
  _____(initial here)

- **Snow Policy:** We will follow Montgomery County's inclement weather school closing policy. This includes evening cancellations for late afternoon or evening appointments. If you have any questions about whether or not our office is open, please call, as we will update our voicemail. **YOU WILL <u>NOT</u> BE BILLED FOR CANCELLATIONS DUE TO POOR DRIVING CONDITIONS**.
  _____(initial here)

- **Safety & Precautions:** Precautions and safety in providing O.T. for your child are carefully monitored through a safe physical environment and the protection of the Occupational Therapist. However, in dealing with movement, especially with children who have difficulty in their motor responses and regulation of behavior, occasional accidents such as bruises, bumps, scrapes, etc. do occur.
  _____(initial here)

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I _____, parent/guardian of _____ have received, read and understand the Policies and Procedures regarding Occupational and Speech Language Therapy and accept the terms of the agreement.

_____
Signature

_____
Date

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Credit Card Authorization

Please use the following card to process payment

Client Name: _____

Credit Card Number: _____
(We accept VISA, MasterCard and Discover)

Name on Card: _____

Billing Address: _____

Billing City, State: _____

Billing Address Zip Code: _____ Expiration Date: _____ / _____

CVV Code (on back of card)_____

Signature _____

Please check here to have your card automatically billed each month _____

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Release of Information

I give permission for Stepping Stones Therapy to contact the following people regarding _____s, therapy and/or evaluation.

_____

_____

_____

_____

_____

_____

_____Parent/Guardian Signature

_____Date

NOTICE OF PRIVATE PRACTICE
HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT
(HIPAA)

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required 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 that are described in the Notice while it is in effect. The Notice takes effect November 18, 2008 and will remain in effect until we replace it.

The Health Insurance Portability & Accountability Act (HIPAA) describes how we may use or disclose your protected health information, with whom that information may be shared and the safeguards we have in place to protect it. This Notice also describes your rights to access and amend your protected health information. You have the right to approve or refuse the release of specific information outside of our Practice except when the release is required or authorized by law or regulation.

THE PRIVACY OF YOUR HEALTH INFORMATION IS VERY IMPORTANT TO US. PLEASE REVIEW THIS NOTICE CAREFULLY!

Use and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operation. For example:

Treatment: We may use and disclose your health information to a physician or other healthcare provider providing treatment to you. In emergencies, we will use and disclose your protected information to provide the treatment you require.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, billing, evaluating practitioners and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you

give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient's Rights section of this notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up related health information.

Marketing Health-Related Services: We will not use your information or media for marketing communication without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law. We may also disclose health information during any judicial or administrative proceedings, in response to a court order or administrative tribunal, and in certain conditions in response to a subpoena, discovery request, or other lawful purposes. We may disclose protected health information for law enforcement purposes, including responses to legal proceedings, information requests for identifications and location, and circumstances pertaining to victims of a crime.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you or your child are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others involved.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody or protected information of inmates or patients under certain circumstances.

Communicable Diseases: We may disclose your protected health information if authorized by law, to a person who might have been exposed to a communicable disease or might otherwise be at risk of contracting or spreading the disease or condition.

Public Health: We may disclose your protected information to a public health authority who is permitted by law to collect or receive the information in regards to some of the following: preventing or controlling diseases, injury or disability, reported births and deaths, or problems with adaptive products.

Research: We may disclose protected health information to researchers when authorized by law, as approved by institutional review boards that have reviewed the information for research proposals to ensure the privacy of your health information.

Parental Access: State laws concerning minors permit or require certain disclosure of protected information to parents, guardians, and persons acting in a similar legal status. We will act consistently with the laws of this State (or if you are treated in another state, the laws of that State) and will make disclosures following such laws.

Appointment Reminders: We may use or disclose health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

Patient's 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 obtain a form to request access by using the contact information listed at the beginning of this Notice. We will charge you a reasonable cost-based fee for providing the health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the beginning of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before September 1, 2007. If you request this account more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: 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 these additional restrictions, but if we do, we will abide by our agreement (except for in emergencies).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to an alternative location. (You

must make this request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you requested.

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

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about your access to your health information or in response to a request you made to amend or restrict the use or disclose of your health information or to have us communicate with you by an alternative location, you may complain to us by using the contact information listed at the beginning of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with the U.S. Department of Health and Human Services or us.

Notice of Private Practice

Health Insurance Portability and Accountability Act

(HIPAA)

I have reviewed the Notice of Private Practice under the Health Insurance Portability and Accountability Act (HIPAA) 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.

_____ Parent Signature

_____ Date