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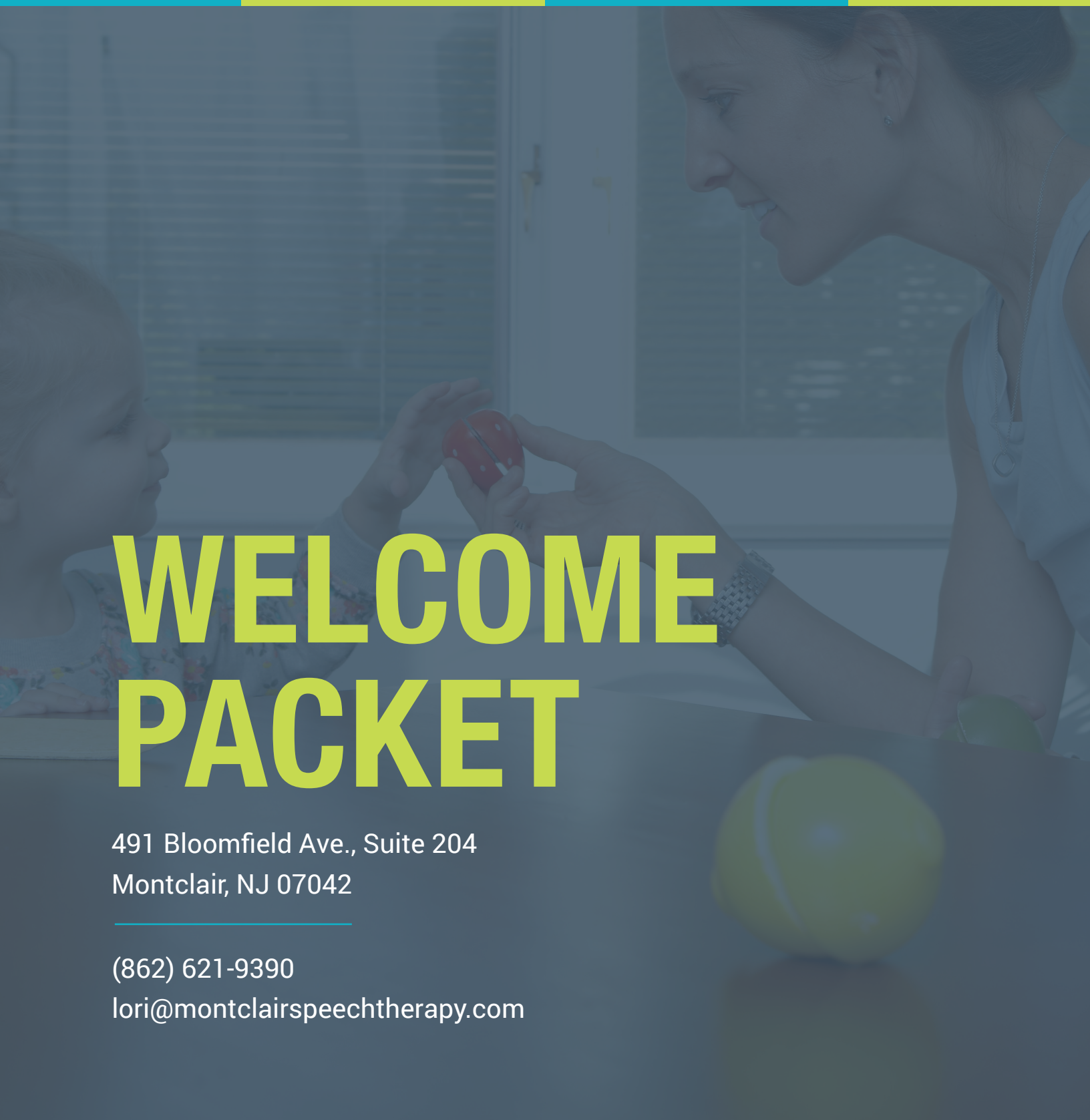
SPEECH THERAPY



WELCOME PACKET

491 Bloomfield Ave., Suite 204
Montclair, NJ 07042

(862) 621-9390
lori@montclairspeechtherapy.com

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SPEECH THERAPY

WELCOME TO MONTCLAIR SPEECH THERAPY!

Thank you for choosing Montclair Speech Therapy to help you or your loved one achieve speech and language goals. We realize that you have options regarding speech therapy for and we are happy you selected us.

This new client paperwork packet includes important information about the therapeutic process, including financial, attendance and privacy policies. Please take the time to fill out the client history form as completely as possible to enable the most accurate treatment plan. Additionally, if you or your loved one has had any recent assessments completed by other health care professionals, including but not limited to an Audiologist, ENT, etc., please provide copies so that we are able to get the whole picture.

Completed form packets may be brought to the initial visit, emailed to me a lori@montclairspeechtherapy.com or mailed to 491 Bloomfield Ave, Suite 204, Montclair, NJ 07042.

We look forward to working with you and/or your loved one!

Sincerely,

Lori Caplan-Colon, M.S., CCC-SLP

Licensed Speech-Language Pathologist
NJ License 41YS00499200
ASHA Certification 12086670

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SPEECH THERAPY

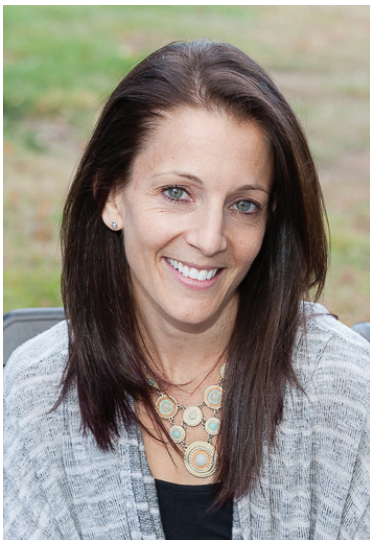
ABOUT MONTCLAIR SPEECH THERAPY

Montclair Speech Therapy provides private speech and language therapy for infants, toddlers, children and adults with speech, language and swallowing disorders. Located in northern New Jersey, we offer outpatient services and in-home treatment for the medically fragile as well as those with moderate and mild impairments.

From Vital Stimulation to Oral Placement Therapy, PROMPT and The S.O.S. Sequential Oral Sensory Approach to Feeding, we employ methodologies and techniques that support evidence-based practices.

Led by licensed Speech Language Pathologist Lori Caplan-Colon, Montclair Speech Therapy successfully builds custom care plans that combine specific therapy approaches and techniques tailored to each patient's needs and goals. We specialize in speech and language disorders, swallowing and feeding disorders, voice and fluency, language-based learning disabilities and cognitive rehabilitation for all ages.

LORI CAPLAN-COLON M.S. CCC-SLP



Lori is a practicing Speech Language Pathologist licensed in the state of New Jersey. She is a certified member of the American Speech Language Hearing Association (ASHA) who obtained her Bachelor of Science degree in Speech Language Pathology at Ithaca College and her Masters degree in Speech Language Pathology at Massachusetts General Hospital Institute of Health Professions.

Lori started her career focusing on adults with speech, language, cognitive and swallowing impairments, becoming vital stimulation certified in 2007 to help patients overcome severe swallowing disorders. Her great rapport and success with adult clients led her to broaden her focus to include the pediatric population, treating children with a range of diagnoses from mild language and speech delays to autism, down's syndrome, chromosomal disorders and brain injuries. Lori's passion for helping others is evident and her confident, compassionate approach to treating medically fragile patients has positioned her as an expert in her field.

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POLICIES & PROCEDURES

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POLICIES & PROCEDURES

APPOINTMENTS

All cancellations must be made with 24 hours notice except under emergency circumstances. If an appointment is not cancelled within 24 hours, a service fee of $35.00 will be charged. No call/No show will be subject to a $75.00 fee. If a cancellation/no show pattern continues, evaluation of eligibility will be completed and potential termination from therapy may be considered. If we need to cancel a therapy session on short notice, we will make every effort to make sure you are aware of the need to reschedule and will find a time that is convenient for you to make up the session.

ATTENDANCE

Following an initial evaluation, a frequency of treatment will be established. A schedule will be discussed and agreed upon. Changes to the schedule can occur following a conversation with the treating therapist, parent/legal guardian and/or client (if over 18 years of age). No call/no show first offense will be charged half the rate of a normal session. All subsequent no call/no show episodes will be charged a full session rate. If you arrive late, we will do our best to accommodate you, but the session may be abbreviated due to schedule and the full rate will be billed.

SESSIONS

Sessions are offered at 30, 45 and 60 minute intervals to meet the needs of our patients. For minor children, the last five-ten minutes of each session will be spent reviewing the session with a parent or caregiver and discussing homework. For home-based therapy sessions,, a parent or designated adult (e.g., babysitter, nanny, grandparent) must be in the home for the duration of the session

CONFIDENTIALITY

Your privacy is very important to us. I recommend that you review the Notice of Privacy Policy for important details about maintaining confidentiality. You will only be contacted via the method(s) chosen on your Contact Information form. It is up to you to make sure contact information is kept current. If you would like Montclair Speech Therapy to exchange information with another person or professional, an Authorization for Release of Information form must
be completed.

FEES

You will be informed of all charges prior to being provided with any type of clinical service.

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SPEECH THERAPY

POLICIES & PROCEDURES

PAYMENT

The person who completes the Party Responsible for Payment form is responsible for payment of all services rendered. Currently, we accept the following insurance carriers: Aetna, Amerihealth, Cigna, Medicare, Magnacare, Horizon Blue Cross Blue Shield of NJ. We offer courtesy billing for our patients, which means that the patient pays Montclair Speech Therapy, but our billing company electronically submits a bill to the insurance company, resulting in reimbursement directly to the patient's home address. Be sure to obtain a reference number following all calls to your insurance carrier. A reference number will support the appeals process as needed. Upon request, documentation of therapy services can be provided so clients can request reimbursement from insurance themselves or an FSA. For private pay individuals, payment is due at the time services are rendered unless you have made other arrangements in advance. For children scheduled for individual therapy without a parent present (e.g., at school), payment should be made in advance or be sent with the child. All accounts more than 30 days overdue will be subject to a $25 late fee and 5% interest charge. All accounts more than 60 days overdue will be sent to collection. Montclair Speech Therapy may, at times, run promotional discounts or provide discounts for families with extenuating circumstances.

CONFIRM ELIGIBILITY - In Network/Out of Network

Insurance plans frequently change, If you are a new or returning patient, it is your responsibility to verify that your insurance carrier covers this office visit. As a courtesy, we will check your insurance benefits. Patients will be responsible for any copays, deductibles, and denials. You can learn about your plan coverage by calling the number provided on your insurance card.

TERMINATION OF SERVICES

Clients may terminate services by phone, email, written notice or in person, at any time, for any reason. In the event that you do not honor your financial obligations to Montclair Speech Therapy and remain delinquent on your account for more than 60 days, services will be terminated. If a client accumulates three no-shows, termination of therapy is warranted. We reserve the right to terminate services if we determine that the therapy schedule is not aggressive enough to guarantee positive outcomes in a reasonable amount of time.

COMMENTS, QUESTIONS, COMPLAINTS

All feedback is encouraged! Montclair Speech Therapy strives to be the best in speech/language therapy. Positive comments are always welcome and information about things we can do better is very valuable. If there is something you are not happy with, please bring it to our attention. There will be no retaliation for complaints.

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SPEECH THERAPY

STATEMENT OF POLICY

CHANGES IN POLICY

Montclair Speech Therapy reserves the right to make policy changes at any time. Clients will be informed of any policy changes prior to their implementation.

WRITTEN STATEMENT OF POLICY

Privacy of personal information is important to Montclair Speech Therapy.
We are committed to collecting, using and disclosing personal information responsibly and only to the extent necessary for the services we provide. This document describes our privacy policies.

WHAT IS PERSONAL INFORMATION?

Personal information is information about identifiable individuals. Personal information includes information that relates to:

- an individual's personal characteristics (e.g., gender, age, home address or telephone number, family status)
- health (e.g., health history, health conditions, health services received by them)
- activities and views (e.g., opinions expressed by an individual, an opinion or evaluation of an individual)

Personal information is different from business information (e.g., an individual's business address and telephone number). This is not protected by privacy legislation.

WHO WE ARE

Montclair Speech Therapy is a speech therapy office servicing pediatric and adult populations for a variety of speech, language, cognitive and swallowing impairments. For an additional fee, Montclair Speech Therapy providers will travel to client homes to provide speech therapy services. We are located at the border of Montclair and Bloomfield, NJ.

WE COLLECT PERSONAL INFORMATION: PRIMARY PURPOSES

Like all medical professions, we collect, use and disclose personal information in order to serve our clients. For our clients, the primary purpose for collecting personal information is to provide treatment.

For example, we collect information about a client's health history, including their family history, physical condition, function and social situation in order to help assess what their health needs are, to advise them

of their options and then to provide the health care they choose. A second primary purpose is to obtain a baseline of health and social information so that in providing on going health services we can identify changes that occur over time.

WE COLLECT PERSONAL INFORMATION: RELATED AND SECONDARY PURPOSES

Like most organizations, we also collect, use and disclose information for purposes related to or secondary to our primary purposes. The most common examples of our related and secondary purposes are as follows:

To invoice clients for goods or services that were not paid for at the time of service, to process credit card payments or to collect unpaid accounts.

Montclair Speech Therapy reviews client and other files for the purpose of ensuring that we provide high quality services.

Speech Language Pathologists adhere to the guidelines set forth by the American Speech and Hearing Association (ASHA). In addition, Montclair Speech Therapy SLP's are licensed in the state of NJ. We abide by the code of ethics as outlined by ASHA.

Clients or other individuals we treat may have questions about our services after they have been received. We retain our client information for a mandatory minimum of seven years after the last contact to enable us to respond to those questions and provide services.

PROTECTING PERSONAL INFORMATION

We understand the importance of protecting personal information. For that reason, we have taken the following steps:

- Paper information is either under supervision or secured in a locked or restricted area.
- Electronic hardware is either under supervision or secured in a locked or restricted area at all times. In addition, passwords are used on computers. Paper information is transmitted through sealed, addressed envelopes or boxes by reputable companies.
- Electronic information is transmitted either through a direct line or has identifiers removed or is encrypted.
- Staff is trained to collect, use and disclose personal information only as necessary to fulfill their duties and in accordance with our privacy policy.

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SPEECH THERAPY

STATEMENT OF POLICY

RETENTION AND DESTRUCTION OF PERSONAL INFORMATION

We need to retain personal information for some time to ensure that we can answer any question the client may have about the services provided and for our own accountability to external regulatory bodies.

We keep our clients files for seven years according to our regulations.

We destroy paper files containing personal information by shredding. We destroy electronic information by deleting it and, when the hardware is discarded, we ensure that the hard drive is physically destroyed.

YOU CAN LOOK AT YOUR INFORMATION

You have the right to see what personal information we hold about you. We can help you identify what records we might have about you. We will also try to help you understand any information you do not understand (e.g., short forms, technical language, etc.). We will need to confirm your identity, if we do not know you, before providing you with this access. We reserve the right to charge a nominal fee for such requests.

If there is a problem, we may ask you to put your request in writing. If we cannot give you access, we will tell you within 30 days if at all possible and tell you the reason, as best we can, as to why we cannot give you access.

If you believe there is a mistake in the information, you have the right to ask for it to be corrected. This applies to factual information and not to any professional opinions we may have formed. We may ask you to provide documentation that our files are wrong. Where we agree that we made a mistake, we will make the correction and notify anyone to whom we sent this information. If we do not agree that we have made a mistake, we will still agree to include in our file a brief statement from you on the point and we will forward that statement to anyone else who received the earlier information.

QUESTIONS, CONCERNS, COMPLAINTS

DO YOU HAVE A QUESTION?

Our Information Officer, Ben Colon, can be reached at:

Montclair Speech Therapy
491 Bloomfield Ave., Suite 204
Montclair, NJ 07042

Phone: (917) 364-9544

If you wish to make a formal complaint about our Privacy Practices, you may make it in writing to our information officer. She will acknowledge receipt of your complaint; ensure that it is investigated promptly and that you are provided with a formal written decision with reasons.

If you have billing questions/concerns you may contact our billing department via phone at:

(941)330-7627 or via email at billing@montclairspeechtherapy.com

If you have a concern about the professionalism or competence of our services or the mental or physical capacity of any of our professional staff we would ask you to discuss those concerns with us. However, if we cannot satisfy your concerns, you are entitled to complain to our regulatory body:

American Speech and Hearing Association at asha.org.

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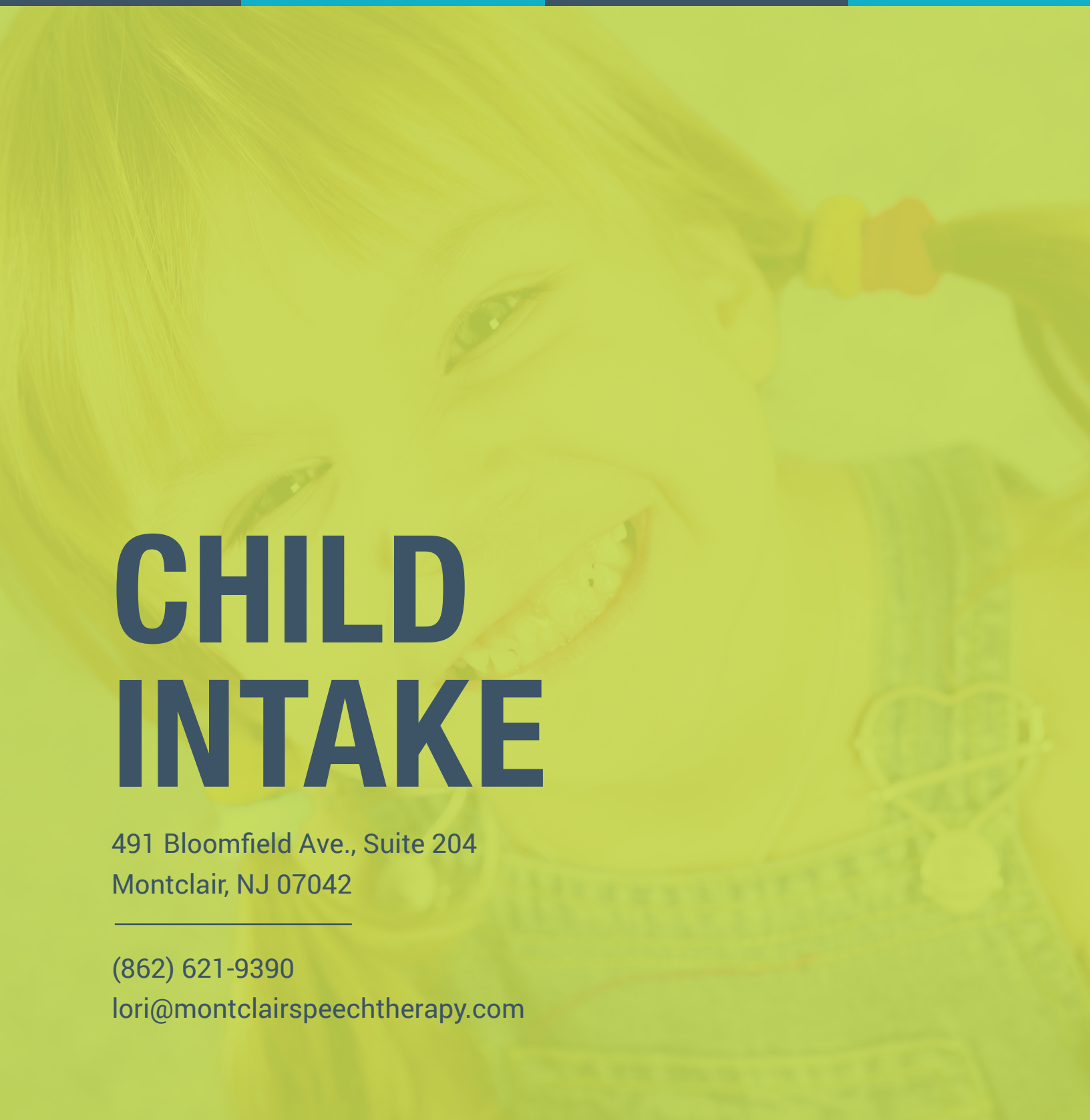

CHILD INTAKE

491 Bloomfield Ave., Suite 204
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INFORMED CONSENT FOR SPEECH THERAPY

I, _____ the parent/legal guardian of _____ hereby request and consent to Montclair Speech Therapy providing treatment and care as prescribed by a physician and/or recommended by a Speech-Language Pathologist.

For minor children, I acknowledge and agree that a parent or legal guardian must be in the home/ waiting area of the office during each treatment session.

I have carefully read and fully understand this Informed Consent Form and have had the opportunity to discuss it with the treating therapist.

I consent and authorize Montclair Speech Therapy to administer treatment under the direction and supervision of a certified Speech-Language Pathologist.

_____

Signature (self or parent/legal guardian)

_____

Date

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SPEECH THERAPY

INTAKE FORM - MINOR CHILDREN

BASIC INFORMATION

Child's Name _____ DOB _____

Child's Address _____

Parent/Guardian Name(s) _____

Email _____ SSN# _____

Phone 1 _____ Phone 2 _____

Child lives with both parents? ☐ YES ☐ NO

Primary language spoken in home: _____

Pediatrician _____ Phone _____

Referral Source: _____

Previous Evaluations (list): _____

Therapy to Date (list): _____

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SPEECH THERAPY

INTAKE FORM - MINOR CHILDREN

Describe present problem: _____

Who noted present problem? _____

When? _____

What is your child's reaction to the problem?

_____

How does the family react to the problem?

_____

Has there been any significant change in last six months? ☐ YES ☐ NO

If so, what? _____

_____

How well is your child understood by (i.e., what percentage of the time):

Mother: _____ Other Children: _____

Father: _____ Extended Family: _____

Younger Siblings: _____ Unfamiliar Adults: _____

Older siblings: _____

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INTAKE FORM - MINOR CHILDREN

Describe what it is like to have a conversation with your child:

_____

_____

PRENATAL/BIRTH HISTORY

Full Term: ☐ YES ☐ NO If no, how many weeks? _____

Birth Hospital: _____

Illnesses or accidents during pregnancy: _____

Use of alcohol, tobacco or medications during pregnancy:

_____

Birth Weight: _____

Delivery: ☐ VAGINAL ☐ CESAREAN ☐ BREECH ☐ FEET FIRST

Other unusual conditions that may have affected pregnancy or birth:

_____

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SPEECH THERAPY

INTAKE FORM - MINOR CHILDREN

MEDICAL HISTORY

Please check if your child has had any of the following (and if so, at what age):

Seizures:	☐ _____	Meningitis:	☐ _____
High Fevers:	☐ _____	Encephalitis:	☐ _____
Measles:	☐ _____	Rheumatic Fever:	☐ _____
Mumps:	☐ _____	Tuberculosis:	☐ _____
Chicken Pox:	☐ _____	Sinusitis:	☐ _____
Whooping Cough:	☐ _____	Chronic Colds:	☐ _____
Diphtheria:	☐ _____	Enlarged Glands:	☐ _____
Croup:	☐ _____	Thyroid:	☐ _____
Pneumonia:	☐ _____	Asthma:	☐ _____
Tonsillitis:	☐ _____	Heart Trouble:	☐ _____

Explain any checked items here:

_____

_____

Are immunizations current? ☐ YES ☐ NO

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SPEECH THERAPY

INTAKE FORM - MINOR CHILDREN

CURRENT MEDICAL HISTORY

** Has your child had any earaches/ear infections? ☐ YES ☐ NO

Please explain here:

_____

Allergies? (Describe)

_____

Any other serious or recurrent illnesses?

_____

Any operations?

_____

Any accidents?

_____

Any medications? Past: _____

Current: _____

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SPEECH THERAPY

INTAKE FORM - MINOR CHILDREN

Vision problems? _____

Treatment: _____

Hearing difficulties? _____

Treatment: _____

Dental problems? _____

Treatment: _____

Other Medical Issues:

_____

DEVELOPMENTAL HISTORY

Age when child: (If you cannot remember specific time, please indicate if it occurred at the expected time or if it was delayed)

Sat up alone: _____ Dressed self: _____

Crawled: _____ Tied shoes: _____

Walked: _____ Fed self independently: _____

Toilet Trained: _____ Weaned from bottle/breast: _____

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SPEECH THERAPY

INTAKE FORM - MINOR CHILDREN

Is your child left or right handed? _____

Able to use: ☐ CUP ☐ SPOON ☐ STRAW

Any Difficulty: (YES/NO)

Swallowing? _____

Chewing? _____

Drinking? _____

Blowing? _____

Drooling? _____

Food Allergies: _____

Favorite Foods: _____

Aversive Foods (if any): _____

Attention span for self-directed activities: _____

Adult-directed: _____

Eating and sleeping patterns:

_____

_____

Does your child respond typically to: (YES/NO)

Light? _____

Sound? _____

People? _____

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INTAKE FORM - MINOR CHILDREN

DOES YOUR CHILD:

Play with others? _____ Who? _____

Eat and sleep well? _____

Cry appropriately? _____

Laugh? _____

Smile? _____

Make wants/needs known? _____ How? _____

_____

Does your child show unusual behavior? (explain)

_____

LANGUAGE DEVELOPMENT

Age when child: (If you cannot remember specific time, please indicate if it occurred at the expected time or if it was delayed)

What was your child's first word(s)?

Spoke first word: _____ _____

Combined words: _____ First sentence? _____

Spoke in sentences: _____ _____

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INTAKE FORM - MINOR CHILDREN

Does your child have difficulty following directions? (describe)

Any speech or hearing problems in the immediate or extended family? (explain)

Names and ages of siblings:

Other adults living in the home:

How does your child handle frustration?

How does your child handle separation?

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INTAKE FORM - MINOR CHILDREN

What motivates your child most?

_____

What discipline methods work best?

_____

_____

SCHOOL HISTORY

Child's Current School and Grade: _____

Child's performance educationally: _____

Receiving special services at school: _____

How does your child's teacher describe his/her performance?

_____

Has the teacher expressed any concern? If so, what?

_____

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INTAKE FORM - MINOR CHILDREN

OTHER

What do you hope to have happen as a result of this evaluation?

_____

Does the report need to be sent to specific agencies? ☐ YES ☐ NO

Where? _____

Anything else you would like us to know?

_____

_____

CONTACT INFORMATION

At times we may need to contact you for appointment reminders or other concerns. Please complete only the items below that you authorize as a method of contact.

Home Address: _____

Phone Number: _____

Email Address: _____

Home Phone OK to leave message: ☐ YES ☐ NO

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INTAKE FORM - MINOR CHILDREN

Mother's Cell Phone: _____

OK to leave message: ☐ YES ☐ NO

Mother's Work Phone: _____

OK to leave message: ☐ YES ☐ NO

Mother's Email Address: _____

Father's Cell Phone: _____

OK to leave message: ☐ YES ☐ NO

Father's Work Phone: _____

OK to leave message: ☐ YES ☐ NO

Father's Email Address: _____

Please select your preferred contact method (one only) for each item listed below:

Appointment Reminders: ☐ MOTHER'S EMAIL ☐ FATHER'S EMAIL ☐ PHONE

Other Correspondence: ☐ MOTHER'S EMAIL ☐ FATHER'S EMAIL ☐ PHONE

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INTAKE FORM - MINOR CHILDREN

PAYMENT INFORMATION (PARTY RESPONSIBLE FOR PAYMENT)

Name _____ DOB _____

SSN# _____ Phone _____

Street Address _____ City _____ State _____ Zip Code _____

Employer Information:

Company Name: _____

Contact Number: _____

INSURANCE

Does the child currently have valid medical insurance? YES ☐ NO ☐

Insurance carrier: _____

Policy holder's name: _____

Group ID: _____

CLIENT ACCOUNTABILITY

If you are a new or returning client, **it is your responsibility to verify that your insurance carrier covers this office visit.** *As a courtesy, we will check benefits. But, it is strongly suggested that you check as well. You will be responsible for any insurance fees. Call the number provided on your insurance card to verify that we participate in your network. Upon completion of your call,* **obtain a reference number**. *Reference numbers are need in case of an appeal.*

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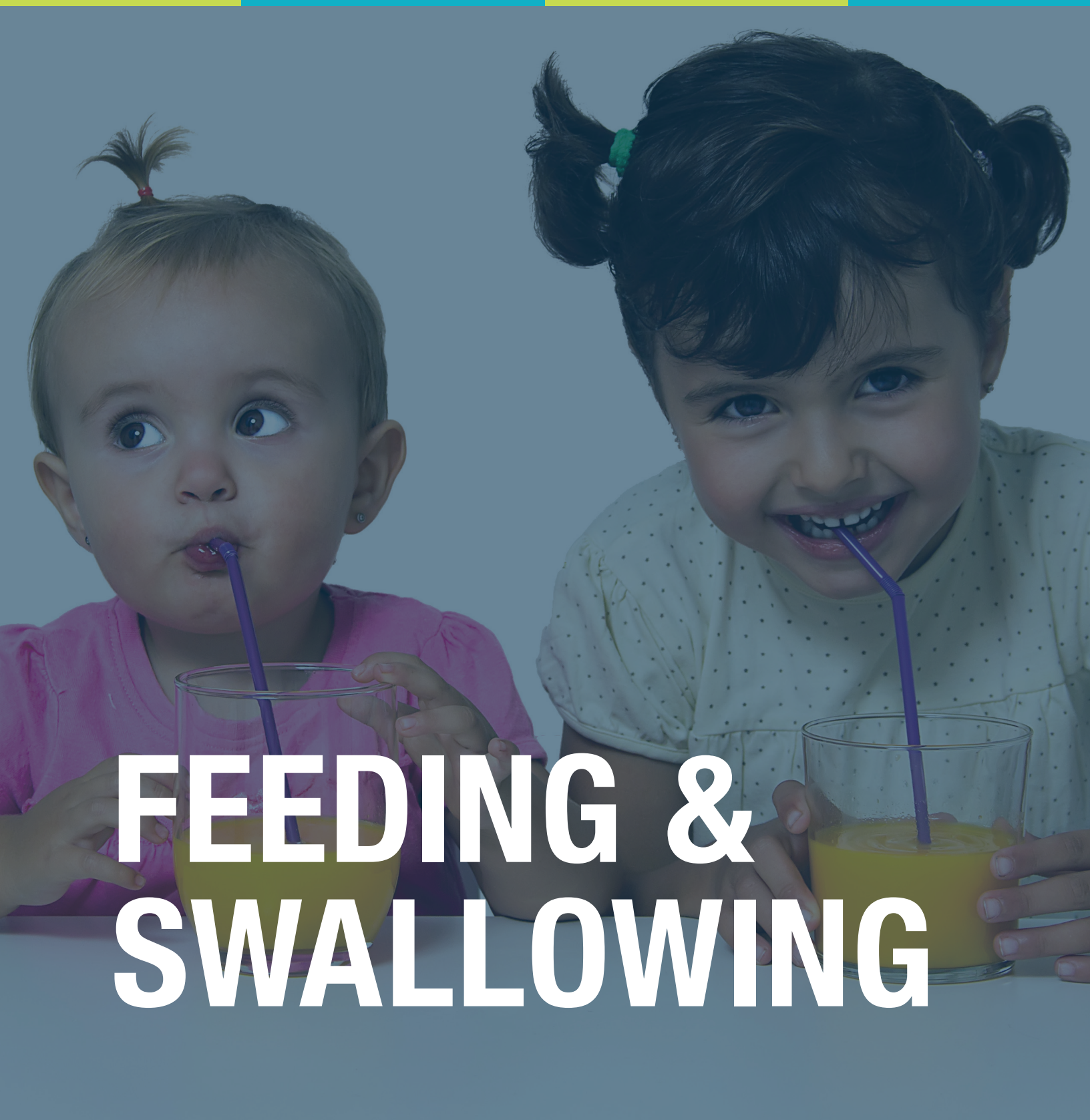

FEEDING & SWALLOWING

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FEEDING AND SWALLOWING INTAKE FORM - MINOR CHILDREN

EATING HABITS

What does your child eat in a typical day? List main foods & amounts per meal.

_____

_____

List main foods & amounts per meal:

Breakfast: _____ _____

Morning Snack: _____ _____

Lunch: _____ _____

Afternoon Snack: _____ _____

Dinner: _____ _____

Evening Snack: _____ _____

How long does it take for your child to finish a meal?

_____

What are your child's favorite foods?

_____

What foods does your child dislike?

_____

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FEEDING AND SWALLOWING INTAKE FORM - MINOR CHILDREN

In what position is your child most comfortable eating? (Check all that apply.)

- ☐ Highchair
- ☐ Chair at table
- ☐ Standing
- ☐ Lap
- ☐ Laying Down
- ☐ Other

What utensils have been introduced? Please indicate at what age. (Check all that apply.)

- ☐ Pacifier
- ☐ Bottle
- ☐ Fingers
- ☐ Spoon
- ☐ Fork
- ☐ Sippy Cup
- ☐ Straw
- ☐ Regular Cup
- ☐ Other

Is any adaptive equipment being used during feedings?

_____

If your child is not using a bottle, when did they transition to a cup?

_____

Does your child self-feed? ☐ YES ☐ NO

At what age did child start self-feeding? _____

What kinds of food does your child eat regularly? Please indicate at what age.
(Check all that apply.)

- ☐ Breastmilk
- ☐ Formula
- ☐ Thin liquids
- ☐ Thickened liquids

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FEEDING AND SWALLOWING INTAKE FORM - MINOR CHILDREN

☐ Pureed food ☐ Mashed table food ☐ Chopped table food

☐ Regular table food ☐ Other

If your child is eating solids, at what age was solid food introduced?

_____

Does your child take any nutritional supplements? If yes, please indicate product, amount & frequency.

_____

How do you know if your child is hungry?

_____

How do you know when your child is full?

_____

Is your child having trouble losing weight?

_____

Is your child having trouble gaining weight?

_____

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SPEECH THERAPY

FEEDING AND SWALLOWING INTAKE FORM - MINOR CHILDREN

Please check off any behaviors that apply to your child during meals:

- ☐ Choking
- ☐ Food or liquid coming out of nose
- ☐ Eats too much
- ☐ Eats too little
- ☐ Difficulty swallowing
- ☐ Trouble breathing
- ☐ Fussy, cranky
- ☐ Spitting out food
- ☐ Pushing food out
- ☐ Delayed swallow
- ☐ Gagging
- ☐ Crying
- ☐ Holding food in mouth
- ☐ Pocketing food in mouth
- ☐ Noisy breathing
- ☐ Wet quality to voice
- ☐ Gagging
- ☐ Reflux
- ☐ Vomiting
- ☐ Falling asleep
- ☐ Refusal to eat
- ☐ Head turning
- ☐ Mouth closing
- ☐ Stiffening
- ☐ Hyperextension
- ☐ Other behaviors

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FEEDING AND SWALLOWING INTAKE FORM - MINOR CHILDREN

Does your child demonstrate negative behaviors during mealtime? (Check all that apply.)

- ☐ Throws food
- ☐ Spits food out
- ☐ Leaves table before done
- ☐ Messy eater
- ☐ Trouble with self-feeding
- ☐ Trouble with chewing
- ☐ Trouble with swallowing
- ☐ Refusal to eat
- ☐ Takes food from other's plate
- ☐ Other _____

Does your child still use a pacifier? ☐ YES ☐ NO

Does your child have difficulty with speech, feeding and/or movements with his/her mouth?

_____

Does your child dislike being touched around his/her mouth? ☐ YES ☐ NO

Does your child drool? If yes, please indicate often, infrequent or occasionally.

_____

What seems to help (or not help) your child during mealtime?

_____

_____