



**Name:** \_\_\_\_\_  Male  Female  
Last First Middle

**If Minor, Name of Parent or Responsible Party:** \_\_\_\_\_

**How Do You Plan to Pay for this Visit?**  Check  Cash  Credit Card

**Address:** \_\_\_\_\_ **Apt No:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Minor's Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Age:** \_\_\_\_\_  
Mo Day Yr

**Social Security No:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_  
(of responsible party) (of responsible party)

**Driver's License:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**Telephone: Home:** ( ) \_\_\_\_\_ **Daytime:** ( ) \_\_\_\_\_

**Cell:** ( ) \_\_\_\_\_ **Email:** \_\_\_\_\_

**Whom Shall We Thank For Referring You?:** \_\_\_\_\_

**Referring Specialist:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone:** ( ) \_\_\_\_\_

**Personal Physician:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone:** ( ) \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Telephone:** ( ) \_\_\_\_\_

**AUTHORIZATIONS:**

May we send other specialists a report of our findings?  YES  NO  
 Do you authorize the discussion of your case or diagnosis with your immediate family?  YES  NO

**BILLING POLICY: PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED, unless special arrangements for payments have been made prior to services. We do not accept insurance for payment of services. I UNDERSTAND THAT I WILL BE FULLY RESPONSIBLE FOR ANY OUTSTANDING BALANCE AND THAT I WILL BE CHARGED A 33% COLLECTION FEE IF MY BALANCE IS 90 DAYS OVERDUE.**

**I have read the above policy and understand my financial responsibility.**

**Date:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ 07/2011



## CHILD HISTORY-INTAKE FORM

### General Information:

Childs Name: \_\_\_\_\_ Dates of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Does child live with both parents? \_\_\_\_\_

Mothers Name: \_\_\_\_\_ Age: \_\_\_\_\_

Mothers Occupation: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Fathers Name: \_\_\_\_\_ Age: \_\_\_\_\_

Fathers Occupation: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Referred By: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Address: \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Pediatrician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Does Child have any siblings? \_\_\_\_\_ If yes please list them including names & ages.

Name: \_\_\_\_\_ Sister/Brother: \_\_\_\_\_ Age: \_\_\_\_\_

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

### Speech-Language Information:

What language(s) does the child speak? \_\_\_\_\_

What language(s) is spoken in the home? \_\_\_\_\_

With whom does the child spend most of his/her time? \_\_\_\_\_

Describe the child's speech-language and/or educational problems: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How does the child usually communicate? (gestures, single words, short phrases, sentences etc): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

When was the problem first noticed? By whom? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has the problem changed (progressed/regressed) since it was first noticed?

\_\_\_\_\_

\_\_\_\_\_

Is the child aware of the problem? If yes, how does he/she feel about it? \_\_\_\_\_

Has the child been seen by any other speech-language pathologist or specialist? Who? When? Where? Why? What were their conclusion or suggestions? Please indicate if you are able to provide any reports pertaining to your child's development.

Is there any known history of speech-language problems or other leaning disabilities in your family? If yes, please describe. \_\_\_\_\_

### **Prenatal and Birth history:**

Mother's general condition during pregnancy? (Illnesses, Accidents, Medications): \_\_\_\_\_

Length of pregnancy \_\_\_\_\_ Length of labor \_\_\_\_\_

General condition \_\_\_\_\_ Birth weight \_\_\_\_\_

Circle type of delivery: HEAD FIRST FEET FIRST BREECH CAESARIAN

Were there any unusual conditions that may have affected the pregnancy or birth? \_\_\_\_\_

### **Medical History:**

Please check any of the following that apply to your child:

- Allergies \_\_\_\_\_
- Frequent colds \_\_\_\_\_
- Dizziness \_\_\_\_\_
- Encephalitis \_\_\_\_\_
- High Fever \_\_\_\_\_
- Measles \_\_\_\_\_
- Pneumonia \_\_\_\_\_
- Tinnitus \_\_\_\_\_
- Asthma \_\_\_\_\_
- Convulsions \_\_\_\_\_
- Draing Ear \_\_\_\_\_
- German Measles \_\_\_\_\_
- Influenza \_\_\_\_\_
- Meningitis \_\_\_\_\_
- Seizures \_\_\_\_\_
- Tonsilitis \_\_\_\_\_
- Chicken Pox \_\_\_\_\_
- Croup \_\_\_\_\_
- Ear Infections \_\_\_\_\_
- Headaches \_\_\_\_\_
- Mastoiditis \_\_\_\_\_
- Mumps \_\_\_\_\_
- Sinustitis \_\_\_\_\_
- Other \_\_\_\_\_

If you checked any of the above conditions please explain: \_\_\_\_\_

Does the child have a history of childhood ear infections? \_\_\_\_\_ If yes, how many in one year? \_\_\_\_\_? Did the child have tubes in his/her ears as a child? \_\_\_\_\_

Has the child had any major surgeries? If yes, what type? When? Where? Why? \_\_\_\_\_

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Describe any major accidents and/or hospitalizations \_\_\_\_\_

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Is the child taking any medication? If yes, identify.

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**Developmental History**

- Crawl \_\_\_\_\_
- Walk \_\_\_\_\_
- Use Toilet \_\_\_\_\_
- Sit \_\_\_\_\_
- Feed Self \_\_\_\_\_
- Stand \_\_\_\_\_
- Dress Self \_\_\_\_\_
- Use single words \_\_\_\_\_ (mama, dada, no)
- Combine Words \_\_\_\_\_ (my toy, mama car, etc)
- Use simple sentences \_\_\_\_\_ (Where's Mama?)
- Name simple objects \_\_\_\_\_ (cat, dog, car, toy)
- Engage in conversation \_\_\_\_\_

Are there or have there ever been any feeding problems (problems with sucking, swallowing, drooling, or chewing...etc.) If yes, describe. \_\_\_\_\_

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Describe the child's response to sound (responds to all sound, responds to loud sound ONLY, inconsistently responds to sounds...etc) \_\_\_\_\_

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Does the child have difficulties attending to tasks? \_\_\_\_\_ If so, please describe in what environments and at what time of the day does attention seem to be most problematic. \_\_\_\_\_

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**Educational Information:**

School: \_\_\_\_\_ Grade: \_\_\_\_\_  
How is the child doing academically (preacademically)? \_\_\_\_\_

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Does the child receive special services? If yes please describe. \_\_\_\_\_

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Has your child ever repeated a grade? \_\_\_\_\_ If so, explain: \_\_\_\_\_

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How does the child interact with others? (shy, outgoing, aggressive) \_\_\_\_\_

List any agencies, psychologists, speech pathologists, tutors, educational therapists and others who have evaluated and/or provide treatment for your child.

Indicate which relatives, if any have had specific learning difficulties or speech and language difficulties.

Comment on any significant academic or physical difficulties that your child has experienced.

In what activities has you child been particular successful and/or interested?

Provide any additional information that might be helpful in evaluating the child problems. \_\_\_\_\_

Person completing form: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_



## Payment Policy

Payment for all therapeutic services is required on the **first of the month** by Visa or MasterCard. Fees for services will be charged on the credit card for the upcoming month. If your child receives services twice a week, your credit card will be charged for 8 sessions. In the event that there are more or less than 8 sessions a month, you will be notified by e-mail for the total amount of sessions and fees you will be charged. **One** cancellation per month is permissible due to illness or other unforeseen circumstances. You will not be charged for this session. If you cancel more than one appointment per month, you will not be issued a credit. It is your responsibility to schedule a make-up session during the same week.

If you are in a situation where you **cannot** use a credit/ debit card, you may pay by cash or check. Payments by cash or check must be paid in full for the whole month by the first of every month. No exceptions will be made. In the event that you make payment with a check, which is returned without payment, you will have 7 days from the time you are notified to make alternate payment. You will be responsible for any bank fees or charges.

Also, Milestones Educational Therapy Institute does not bill insurance companies. It is the parent/ guardian's responsibility to notify insurance companies. We are more than happy to provide you with a bill of service, which you can submit to your insurance company.

If you have any questions please e-mail us at [milestonesedtherapy@gmail.com](mailto:milestonesedtherapy@gmail.com).

Thank you for adhering to this policy.

\_\_\_\_\_ Yes, I wish to receive a bill every month of services charged.

\_\_\_\_\_ No, I do not wish to receive a bill every month of services charged.

I, \_\_\_\_\_, have read and understand these policies. I agree to fully comply with what is written above. I give Milestones Educational Therapy Institute permission to charge my credit card on the first of every month.

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## Insurance Reimbursement Policy

Dear New Patients,

We are able to provide you with billing claim forms that can be submitted to your insurance company. We require a prescription from your doctor with a diagnosis and a diagnosis code (to be updated monthly). Without this prescription on file we are unable to provide you with this information. Please fax all prescriptions to 310.577.1837.

It is our policy to not bill insurance directly. However, many of our families do submit their bills for partial reimbursement. In general, we have found reimbursement to be poor. **We do not contact, follow up with, or submit paper work to your insurance company directly.**

Thank you,

Judith Benn, MA  
Educational Therapist  
Certified Dyslexia Remediation Specialist

I agree to provide Milestones Educational Therapy Institute with a prescription if I choose to seek insurance reimbursement:

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Signature

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Date



## CREDIT CARD AUTHORIZATION

I am an  existing  new patient/client of Milestones Educational Therapy Institute.

I hereby appoint the billing staff of Milestones Educational Therapy Institute for the purpose of signing any documents necessary to purchase therapy services and to charge these purchases to my credit card below:

Credit Card Type:  **VISA**  **MASTERCARD**

Name on Above Card: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_

CVC: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Credit Card Billing Address: \_\_\_\_\_

\_\_\_\_\_

Specific Service Purchased: \_\_\_\_\_

I authorize Milestones Educational Therapy Institute to debit my credit card shown above for the purchase of therapy services.

I agree that I will pay for all such services and will not hold Milestones Educational Therapy Institute responsible for any actions pursuant to this agreement.

Attached to this authorization; I am enclosing a clear photocopy of both the front and rear of my credit card.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Milestones Educational Therapy Institute, LLC Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. At Milestones Educational Therapy Institute, LLC, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your Insurance Company. We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may share your medical information with our business associates, such as a billing service, in a confidential manner. We have a written contract with each business associate that requires them to protect your privacy as well.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In a medical emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new doctor owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will fax or mail your files for you. You have the right to see and receive a copy your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your requests to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. If needed, you may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our office directly at (310) 577-1800.

As required by a new federal law, this notice goes into effect as of April 14, 2003.

**Acknowledgement:** I have received a copy of the Milestones Educational Therapy Institute LLC Notice of Privacy Practices.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Name of Patient: \_\_\_\_\_

