



**Pediatric Speech-Language Therapy**  
**“Always Cultivating Responses”**

**Patient Intake Packet**

Date: \_\_\_\_\_ Patient Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_ M \_\_\_ F \_\_\_  
Mother/Caregiver name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Cell: \_\_\_\_\_ Work: \_\_\_\_\_ Email: \_\_\_\_\_  
Father/Caregiver name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Cell: \_\_\_\_\_ Work: \_\_\_\_\_ Email: \_\_\_\_\_

I agree to receive patient information/invoicing via email:  YES  NO

Primary Care Physician: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_  
Address: \_\_\_\_\_

**Payment**

(Check all payment sources available).

\_\_\_ Group Health Plan \_\_\_ Individual Policy \_\_\_ Medicaid/CMO \_\_\_ Worker’s Compensation/Litigation

**Responsible party**

Name of insurance holder \_\_\_\_\_ Date of birth \_\_\_\_\_  
Address (street) \_\_\_\_\_ (apt./lot) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
Phone (home) \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
Employer \_\_\_\_\_ Phone \_\_\_\_\_  
Primary insurance \_\_\_\_\_ Plan type/Name \_\_\_\_\_  
ID number \_\_\_\_\_ Group number \_\_\_\_\_  
Secondary insurance \_\_\_\_\_ ID number/Group number \_\_\_\_\_

**Is there any other Health Benefit Plan? Y \_\_\_ N \_\_\_ If your answer is yes, please let us know.**

**1075 Cooper Road, Suite 100**  
**Grayson, GA 30017**

**Phone: 678-587-5995 Fax: 470-219-5336**  
**Email: support@acrspeakingdimensions.com**  
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*Assignment of Benefits*

My insurer (Medicaid, CMO's, insurance company, attorney, etc.) is hereby requested to pay directly to any monies due on my behalf. I understand that in Medicaid assigned benefits or other claims, ACR Speaking Dimensions, Inc agrees to accept the payment determination of the carrier as full payment and I am only responsible for the deductible, coinsurance, out of network costs and non-covered services on my claim. I agree to pay, ACR Speaking Dimensions, Inc. the deductible, coinsurance, out of network costs and non-covered services on my claim as soon as notified. I understand that I am responsible for all of the fees not covered by insurance, Medicaid, CMO's, etc., if it is determined that such coverage does not exist or has been terminated for any reason. I understand that I am responsible for staying up-to-date regarding my insurance coverage. I understand that I must inform ACR Speaking Dimensions, INC with any coverage or benefit changes immediately and cannot hold the provider responsible for any such changes. **Therapy services, although might be covered, are still the responsibility of guarantor.** Any claims to insurance company(s) are filed out of courtesy for the patient by the provider. The provider will make two attempts with insurance company to process the claim. If insurance continues to deny, patient/guarantor is responsible for payment of services in full and must contact insurance company. **I will provide my insurance card and identification with any updates/policy change promptly.**

Name of responsible party (*print*) \_\_\_\_\_ Date \_\_\_\_\_

Signature of responsible party \_\_\_\_\_



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***Patient Authorization to Evaluate and Treat***

I authorize ACR Speaking Dimensions, INC. to give my child a speech and language evaluation and for my child to participate in speech/language therapy, if recommended. Therapy and evaluations will be provided at the speech-language therapy clinic of ACR Speaking Dimensions, INC. via in-person, teletherapy, child’s daycare, or private school, as agreed upon by both parties involved.

Responsible Party (*print*): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

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



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**Authorization to Release Information**

Name of Child: \_\_\_\_\_ Date of Birth \_\_\_\_\_

I hereby authorize ACR Speaking Dimensions, INC to release all valuable speech-language, educational, psychological, medical (other) \_\_\_\_\_ information on my child in order to determine the most appropriate treatment program.

Records are to be released to:

Name of institution/office/professional: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

*\*I understand that the information contained in my or my child's medical/school records is confidential and will be released only upon my signature.*

Print name parent/guardian \_\_\_\_\_

Signature of parent/guardian \_\_\_\_\_

Date \_\_\_\_\_

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Child Case History Form

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ M \_\_\_ F \_\_\_

**Reason for Referral**

What concerns do you have about your child's communication skills? \_\_\_\_\_

When was the communication difficulty first noticed? \_\_\_\_\_

Has it changed since it was first noticed? If yes, how? \_\_\_\_\_

**Prenatal and Birth History:**

Mother's general health during pregnancy (illnesses, accidents, medications, etc):

Length of pregnancy/labor: \_\_\_\_\_ Delivery type: \_\_\_\_\_

Birth weight: \_\_\_\_\_ Any complications at birth? \_\_\_\_\_

**Medical History:**

Has your child been hospitalized? If so, what was the reason? \_\_\_\_\_

Has your child had any serious injuries? If so, please explain. \_\_\_\_\_

Describe any major illnesses? \_\_\_\_\_

How often does your child get ear infections? \_\_\_\_\_

Medications? \_\_\_\_\_ Allergies? \_\_\_\_\_

Date/results of your child's last vision or hearing screening? \_\_\_\_\_

**Developmental Milestones (at what age):**

Babble \_\_\_\_\_ First Word \_\_\_\_\_ Phrases (2 or more words) \_\_\_\_\_ Sit \_\_\_\_\_ Crawl \_\_\_\_\_

Stand \_\_\_\_\_ Walk \_\_\_\_\_ Potty Trained \_\_\_\_\_

Comments about development: \_\_\_\_\_

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**Family History**

How many siblings? \_\_\_ Names and ages? \_\_\_\_\_

Does anyone else in the family have speech/language difficulties? \_\_\_\_\_

Do family members have difficulty understanding your child’s communication exchanges? \_\_\_\_\_

Is your child aware of communication difficulties? \_\_\_ If yes, how does he/she feel about it? \_\_\_\_\_

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

What system of consequences/rewards do you have when your child misbehaves or does a good job? (please explain) \_\_\_\_\_

What are your child’s interests? \_\_\_\_\_

What does your family enjoy doing together? \_\_\_\_\_

**Other Therapy Services**

Does your child currently receive any other therapy (Speech Therapy, Occupational Therapy, Physical Therapy, Music, etc.) YES/NO If yes, please explain \_\_\_\_\_

Has your child received any other therapy in the past? YES/NO If yes, what therapy and purpose? \_\_\_\_\_

Does your child have an Individualized Education Plan (IEP)/Individualized Service Plan (ISP)? YES/NO If yes, a copy needs to be provided to proceed with therapy.

**Education**

Academic Strengths/Challenges? \_\_\_\_\_

Any Grades Repeated? YES?NO What grade(s)?: \_\_\_\_\_

Behavioral/Social/Emotional Concerns? \_\_\_\_\_

Name (print) of the person completing these forms: \_\_\_\_\_ Signature: \_\_\_\_\_

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

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**Acknowledgement That You Have Received Our HIPAA Privacy Notice**

ACR Speaking Dimensions, INC is required by law to keep your health information safe. This information may include:

- Notes from your doctor, teacher, or other healthcare provider
- Medical history
- Test results
- Treatment notes
- Insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information may be used and shared.

**I acknowledge that I have received a copy of HIPAA Notice of Privacy Practices that fully explains the uses and disclosures they will make with respect to my individually identifiable health information.**

**I have had the opportunity to read the notice and to have any questions regarding the notice answered to my satisfaction.**

**I understand that ACR Speaking Dimensions, INC cannot disclose my health information other than as specified in the notice.**

**I understand that ACR Speaking Dimensions, INC reserves the right to change the notice and the practices detailed therein and if it does, a revised copy of the notice will be sent to the email address I have provided.**

Print Name of Client: \_\_\_\_\_ Client Date of Birth: \_\_\_\_\_

Name of Legal Representative \_\_\_\_\_

Signature of Client or Legal Representative \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

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