Cobblestone
Speech, Language & Learning

Child Intake Form **Date:**

Child Last Name:_____

Child First Name:_____

Child DOB:_____ Age: _____ Gender: _____

School (if applicable) : _____Grade: _____ (if applicable)

Address: _____ Apt: _____

City:_____ State: _____ Zip: _____

Family Information

Mother's Name:	Mother's Employer & Title:

Mother's Primary Phone (please check one) : _____ ☐H ☐C ☐ W

Mother's Secondary Phone (please check one) : _____☐H ☐C ☐ W

Mother's Email Address: _____

Father's Name:	Father's Employer & Title:

Father's Primary Phone (please check one) : _____ ☐H ☐C ☐ W

Father's Secondary Phone (please check one) : _____☐H ☐C ☐ W

Father's Email Address: _____

Are parents married? ☐ Yes ☐ No (If parents are not married we will need two signed 'Consent To Treat a Minor' forms, one from each parent before we can provide services).

Does the attending parent have sole custody and medical decision making? ☐ Y ☐ N

With whom does your child live: ☐ Both Parents ☐ Mother ☐ Father ☐ Other_____

Name of Siblings	Age	Gender
		☐ F ☐M
		☐ F ☐M
		☐ F ☐M
		☐ F ☐M

How did you hear about us? _____

Referred by: _____

Primary Reason for this referral:

_____

_____

Healthcare Provider Information:

Pediatrician Practice: _____

Pediatrician Name: _____

Pediatrician Phone: _____Pediatrician Fax: _____

Pediatrician Address:_____

City:_____State:_____Zip:_____

Related History

Has your child's vision been tested recently? Yes ▢ No ▢

Result : ▢ Pass ▢ Did not pass (please provide documentation reports)

Has your child had a hearing testing/screening:

▢ No

▢ Yes date: _____

Result: ▢ Pass ▢ Did not pass (please provide documentation reports)

Has your child received any of the following services?

☐ Speech Therapy
☐ Occupational Therapy
☐ Physical Therapy
☐ Psychology/Psychiatry
☐ ABA
☐ Other _____

Has your child been diagnosed with any of the following? (please check all that apply):

☐ ADD
☐ ADHD
☐ Anxiety Disorder
☐ Mood Disorder
☐ Sleep disorder
☐ Autism Spectrum Disorder
☐ Cognitive Delay
☐ Learning Disorder
☐Genetic Disorder
☐ Ear infections
☐ Ear, nose, throat, airway disorders or illnesses
☐ Other _____

Please list any other medical/developmental diagnoses that have been documented for your child:

_____

_____

Has your child been screened or evaluated by:

Child Find ☐ Y ☐ N

Receiving Early Intervention services ☐ Y ☐ N

Public School ☐ Y ☐ N

Does your child have an Individualized Education Plan (IEP)? ☐ Y ☐ N

Does your child have a 504 Plan? ☐ Y ☐ N

Does your child have a READ Plan? ☐ Y ☐ N

Has your child had a previous speech/language evaluation? ☐ Y ☐ N

*Please provide documentation of the above

I (or another caregiver) have concerns about my child in the following areas: (please check all that apply):

☐ Expressive Language
☐ Receptive Language
☐ Reading Comprehension/fluency
☐ Intelligibility - Being understood by others
☐ Articulation of sounds
☐ Fluency/stuttering
☐ Written Language/spelling
☐ Social Communication
☐ Auditory Comprehension
☐ Swallowing/Feeding
☐ Eating a Variety of Foods/Textures
☐ Voice Quality
☐ Hearing Difficulty
☐ Routines/transitions
☐ Attention
☐ Memory
☐ Other _____

My child can be described as: (please check all that apply):

☐ Cooperative
☐ Easily distracted/short attention
☐ Poor eye contact
☐ Attentive Impulsive
☐ Plays Alone
☐ Willing to try new activities
☐ Restless Withdrawn
☐ Easy going/flexible
☐ Separation Difficulties
☐ Difficulty making friends
☐ Socially Outgoing
☐ Easily frustrated
☐ Makes off topic comments
☐ Mature for age
☐ Immature for age
☐ Aggressive
☐ Will go on and on about a topic of interest
☐ Stubborn
☐ Difficulty transitioning between tasks/activities
☐ Other_____

Who has expressed these concerns?

☐ Pediatrician
☐ Dentist
☐ Parents
☐ Teacher/school
☐Other family members
☐ Other _____

Is your child showing signs of frustration stemming from the above concerns (if "yes", please describe):

_____

_____

Please list any medications your child is taking:

Medication:	Purpose	Frequency

Family History

Are there any (immediate and/or extended) family history of:

Speech and/or language difficulties ☐ Y ☐ N

Stuttering ☐ Y ☐ N

Physical Difficulties ☐ Y ☐ N

Sensory Disorders ☐ Y ☐ N

Learning Difficulties/Dyslexia ☐ Y ☐ N

Developmental Disorders ☐ Y ☐ N

Other: ☐ N ☐ Y (if yes, please explain) _____

Is there a language other than English spoken at home or in school? (if yes, please specify)

_____

What language would you consider to be your child's dominant language? _____

Have there been any major life changes (i.e. divorce, new child, death in family, etc.) that you feel could be affecting your child in any way? (if yes, please describe)

_____

_____

Birth/Development History

Is your child adopted? ☐ No ☐ Yes If yes, age of adoption? _____

Length of Pregnancy: _____ Length of Labor: _____

Type of Delivery: ☐ head first ☐ feet first ☐ breech ☐ Cesarean

Please Describe any complications during pregnancy or delivery:

_____

_____

Child's Infancy and Toddlerhood:

Did your child appropriately meet the following developmental milestones?

☐ Sitting up ☐ Rolling ☐ Walking

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

When did your child say his/her first word(s)?_____

How many words in current vocabulary? _____

Phrases or sentences: _____

Any Feeding Difficulties (e.g., problems with sucking, swallowing, drooling, chewing, etc) ☐ N ☐ Y

(please explain): _____

Colic or "fussy baby" ☐ N ☐ Y (please explain): _____

Sleeping Problems? ☐ N ☐ Y (please explain): _____

Thumb Sucking/Pacifier ☐ N ☐ Y (up to what age?) _____

Parent Report

Please describe your child's strengths: _____

_____

Please describe some of your child's favorite activities, toys and interests:

_____

_____

Do you have goals/desired outcomes that you would like to share?

_____

_____

Please describe tasks that are difficult for your child. How do they handle these tasks?

_____

_____

Are there any medical precautions the therapist should be aware of when working with your child? _____

_____

_____

Is there anything else you would like for us to know about your child? _____

_____

_____

Consent to Treat a Minor

This consent Form provides Cobblestone Speech Language and Learning with the authority to provide evaluations, treatment, and consultative services as well as the authority to exchange and share information with previously specified therapists, physicians and/or service providers for my child. We/I acknowledge that no guarantees have been made to me as to the results of treatment of my child. We/I hereby give consent to Cobblestone Speech Language and Learning to treat my child.

_____

First and last name of person completing this form

_____

Email address of person completing this form

_____

Signature and date

Cobblestone Speech, Language and Learning
10579 Bradford Road Suite 104 Littleton, CO 80127
Phone: 303-952-9038
Fax: 720-389-7067
www.CobblestoneSpeech.com

Permission for Audio/Video recording and Graduate Student Observation

On occasion, therapy sessions are videotaped as they are often a necessary part of assessment and intervention . These recordings are used to improve treatment outcomes and document progress. On Occasion, these videos are used for training purposes. Identifying information is limited to the child's first name and age at the time of the recording. All video and audio recordings are securely stored. Copies of the recordings are available to you, the parents, on request.

Please check the appropriate box below and sign, indicating your authorization for use of audio and/or visual recordings.

☐ I AUTHORIZE THE USE OF VIDEO TAPES FOR THE PURPOSE OF TRAINING.

Parent signature:_____ Date: _____

☐ I DO NOT AUTHORIZE THE USE OF VIDEO TAPES FOR THE PURPOSE OF TRAINING.

Parent signature:_____ Date: _____

Occasionally, we have students completing observation hours at our clinic as part of their undergraduate/graduate training in Speech Language Pathology. Please let us know if you are willing to have a student observe your child's session with his/her therapist:

Parent signature:_____ Date: _____

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU AND/OR YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Cobblestone Speech, Language & Learning LLC has a legal obligation to maintain the privacy of the Protected Health Information (PHI) in the records that we maintain, use and disclose as a result of treatment by us.

We are required to provide you with this Notice of Privacy Practices with regard to your PHI.

How We May Use and Disclose Health Information About You
The following categories describe different ways that we may use and disclose PHI.

For Treatment
We may use PHI about you and/or your child to provide you with treatment or services. We may share PHI with another health care professional who needs to be consulted with respect to your care. For example, PHI may be disclosed to a physician that provides care for you and/or your child.

For Payment
We may use and disclose PHI so that we may bill for treatment and services that you and/or your child receive at Cobblestone Speech, Language & Learning LLC. This may include determinations for eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. In the event that a bill is overdue we may give PHI to a collection agency as necessary to help collect the bill or may disclose an outstanding debt to credit reporting agencies.

Appointment/Scheduling Reminders
We may use PHI to contact you to remind you that you and/or your child have or may need to schedule an appointment for treatment or a follow-up evaluation.

Individuals Involved in Your Care or Payment for Your Care
We may release PHI to a person who is involved in your and/or your child's care or helps pay for your and/or your child's care, such as a family member.

As Required by Law
We may use or disclose PHI when required to do so by international, federal, state or local law without first obtaining your authorization. Examples of these situations may include but are not limited to:

- Threat to Health or Safety: We may use and disclose PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- Public Health Risks: We may disclose PHI for public health activities. These activities generally include disclosures to: a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; prevent or control disease, injury or disability ; report births and deaths; report child abuse or neglect; report reactions to medications or products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been a victim of abuse, neglect or domestic violence and the patient agrees or we are required by law to make such a disclosure.

Cobblestone
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Notice of Privacy Practices (Cont'd)

- Military and Veterans: If you are a member of the armed forces, we may release PHI as required by military command authorities. We may also release PHI to the appropriate foreign military authority if you are a member of a foreign military.
- Health Oversight Activities: We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- Law Enforcement: We may release PHI if asked by a law enforcement official for the following reasons: in response to a court order, subpoena, warrant, summons or similar process; limited information to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain circumstances, we are unable to obtain the person's agreement; about a death we believe may be the result of criminal conduct; about criminal conduct on our premises; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.
- National Security and Intelligence Activities and Protective Services: We may release PHI to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.
- Inmates/Correctional Institutions: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI to the correctional institution or law enforcement official.

Your Rights Regarding Health Information About You
You have the following rights, subject to certain limitations, regarding PHI we maintain about you.

Right to Inspect and Copy
You have the right to see and receive a copy of PHI contained in clinical, billing and other records pertaining to your and/or your child's treatment. Your request must be in writing. You may be charged related fees (such as copy or postage fees).

Right to Request Amendments
If you feel that the PHI that we maintain is incorrect or incomplete, you may ask us to amend our information. Your request must be in writing and must include a reason for the request.

Right to an Accounting of Disclosures
You may request a list of disclosures of PHI related to you and/or your child. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment or healthcare operations where an authorization was not required.

Right to Request Restrictions
You may request a restriction or limitation on the PHI that we use or disclose for treatment, payment or health care operations. You also have the right to request a restriction on the health information we disclose to someone involved in your care, such as a family member or friend. We are not required to agree with your request. If we do agree, we will comply with your request unless the information is needed to provide treatment.

Notice of Privacy Practices (Cont'd)

Right to Request Confidential Communications
You have the right to request that we communicate with you about certain medical matters in a certain way or at a certain location.

Right to a Paper Copy of this Notice
You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this notice at any time.

Right to File a Complaint
Anyone can file a health information privacy or security complaint. Your complaint must:

- Be filed in writing by mail, fax, e-mail, or via the OCR Complaint Portal (https://ocrportal.hhs.gov)
- Name the covered entity or business associate involved, and describe the acts or omissions, you believed violated the requirements of the Privacy, Security, or Breach Notification Rules
- Be filed within 180 days of when you knew that the act or omission complained of occurred. OCR may extend the 180-day period if you can show "good cause"

HIPAA Prohibits Retaliation
Under HIPAA an entity cannot retaliate against you for filing a complaint. You should notify OCR immediately in the event of any retaliatory action.

If you believe that your privacy rights have been violated, you may file a complaint with:

Cobblestone Speech, Language & Learning LLC
10579 Bradford Road, Suite 104
Littleton, CO 80127

Or

U.S. Department of Health & Human Services
Office for Civil Rights
Centralized Case Management Operations
200 Independence Avenue, S.W.
Suite 515F, HHH Building
Washington, D.C. 20201
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: ocrmail@hhs.gov
Website: http://www.hhs.gov/hipaa

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 PHI we already have, as well as any information we receive in the future. We will post any revisions of this notice in our office.

Effective Date of this Notice
This Notice of Privacy Practices is effective starting on January 1, 2011.