Chatting Children Speech and Language Center, LLC
20604 Gordon Park Square, Suite 190
Ashburn, VA 20147
Phone: (540) 249-6221
Email: chattingchildren@gmail.com
Website: www.chattingchildren.com

Child's Name: _____ Date of Birth:_____ Today's Date: _____

Address: _____

Phone:_____
(home) (work) (cell)

Mother's Name: _____ Father's Name: _____

Mother's Occupation: _____ Father's Occupation: _____

Mother's email address: _____ Father's email address: _____

Name,Phone, Email of Nanny/Caregiver: _____

Siblings (include names and ages): _____

Referred by: _____

Pediatrician: _____ Phone: _____

Dentist/Orthodontist: _____ Phone: _____

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

Names/Professions: *Phone Numbers:*

_____

_____

_____

Is your child currently being treated by another speech-language pathologist? If so, please provide their name, telephone number and email.

_____

Does your child attend school, day-care or any other program? If so, please specify the name of program, days attended and length of day.

_____

Medical History

How was the mother's general health during pregnancy (please explain)?

_____

_____

Were there any complications during labor and/or delivery (please explain)?

_____

_____

Was your child born premature? If so, please provide details as to difficulties and treatment.

_____

_____

Apgar scores: _____ Birth weight: _____

Has your child ever been given a medical diagnosis? If so, please provide: _____

Has your child had any surgeries? If so, what type and when? _____

Has your child ever suffered from ear infections? _____ How many? _____ Which ear(s)? _____
PE tubes placed? Yes ☐ No ☐ If yes, at what age? _____

Has your child's hearing been tested? If yes, please indicate when, where, and results:

_____

Does your child currently take any medications? If yes, please list: _____

Does your child have any allergies? If yes, please list _____

Is your child on a special diet? Please list any dietary restrictions:

_____

_____

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., fire trucks)

_____

Have any family members been diagnosed with Autism? _____

Have any family members been treated by a speech-language pathologist? Please describe.

_____

_____

Feeding History

Was your child nursed and if so, for how long? _____Bottle Supplementation: Yes ☐ No ☐

Was your child bottle fed and if so, for how long? _____

Was there anything remarkable about your child's early feeding history? If so please describe: (ex: difficulty with latch, difficulty expressing milk from bottle/nipple, noisy eater, clicking sounds, shortness of breath, gassy/colicky, reflux, feeds taking greater than 30 minutes, etc.)

_____

_____

Has your child ever been diagnosed with a lingual restriction (i.e. tongue tie)? Yes ☐ No ☐

If yes, did the child undergo surgical release? Yes ☐ No ☐ Date _____

Present Eating Habits

Is your child a messy eater? Does food/liquid fall out of their mouth? _____

Is your child a noisy eater? (i.e loud breathing or chewing) _____

Does your child have any "problem foods" due to difficulty chewing/swallowing it? If yes, please list:

_____

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

Rate of eating (fast/slow/typical): _____

Please add any additional info regarding your child's typical eating habits:

_____

_____

Upper Respiratory History

Does your child favor (use more often) mouth breathing ☐ nasal breathing ☐ combination ☐

Does your child have seasonal allergies? If yes, please describe and include any treatment/medications:

_____

Does your child have frequent/recurrent colds/bronchitis/sore throat/sinusitis? _____

Does your child snore? Yes ☐ No ☐

Has your child ever had surgical removal of their tonsils/adenoids/turbinates? If so, please describe and provide date of removal: _____

Sleep Habits

Please describe your child's sleeping patterns: _____

Does your child typically wake up well-rested? _____

Does your child exhibit any difficulty sustaining attention (e.g. paying attention at school, listening to a story, etc.)?

_____

Oral Habits

Does/did your child suck their thumb/finger/pacifier? No☐ Yes ☐

At what age did they stop? Age: _____ OR Currently sucks thumb/finger/pacifier ☐

Does your child use an open cup? ☐ Sippy cup? ☐ Straws? ☐

Does your child drool? If yes, please describe: _____

Can your child blow bubbles? Yes ☐ No ☐

Developmental History

Please provide the approximate age at which your child began doing the following activities:

Crawl: _____ Walk: _____ Feed Self: _____ Use toilet _____

Use single words (e.g., mama, no, plane): _____

Combine Words (e.g., daddy car, eat cookie): _____

Engage in conversation: _____

What language(s) are spoken in the home? _____

Do **you** understand your child when he/she communicates? _____

Do **others** understand your child when he/she communicates? _____

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

_____

Does your child repeat sounds, syllables or words within an utterance (e.g., "b-b-b-ball")?

_____

How often does your child repeat sounds/syllables/words? _____

Does your child make eye contact with others? _____

How does your child interact with other children and adults (e.g., shy, aggressive, uncooperative, etc.)?

_____

Describe your child's activity level (low, typical, high): _____

Does your child exhibit any unusual behaviors or have any unusual interests? If yes, please describe:

_____

_____

What activities does your child enjoy the most?

_____

_____

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

How much time does your child spend watching TV per day? _____

How is your child doing academically (or pre-academically)?

_____

_____

If enrolled for special education services, has an Individualized Education Plan (IEP) or other specialized plan been developed? If yes, what services are included? Please provide a copy of the IEP or plan.

_____

Which of the following concerns do you have? (check all that apply)

___☐___ 1) your child's overall articulation (pronunciation of words)
___☐___ 2) your child's comprehension of language
___☐___ 3) your child's ability to use language to converse
___☐___ 4) your child's eating habits
___☐___ 5) your child's dysfluent speech (stuttering)
___☐___ 6) your child's ability to read
___☐___ 7) your child's phonological awareness skills (pre-reading skills such as rhyming,sound ID)
___☐___ 8) your child's auditory processing
___☐___ 9) your child's play/social skills
___☐___10) your child's orofacial myofunctional skills (using the muscles of the mouth and face to breathe, speak, and eat)

Who recommended that you see a speech-language pathologist? _____

Please provide any additional information that might be helpful in the evaluation or remediation of your child's speech and language problem.

_____

_____

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CONSENT TO RELEASE/OBTAIN INFORMATION

I, _____ (parent/guardian), give my permission to Chatting Children Speech and Language Center, to RELEASE and OBTAIN information regarding my child _____ to/from the following professionals, physicians, programs, schools or other individuals:

NAME:	**CONTACT INFORMATION:**
_____	_____
_____	_____
_____	_____
_____	_____

_____

Parent/Guardian Signature Date

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Fee Schedule

Comprehensive Language Evaluation ……. $600.00
- Fee includes one hour of testing, full comprehensive written report, discussion with parents

Speech-Language screening (for articulation assessments)..... $300.00
-Fee includes one hour of testing, a written report and a brief conversation with the parents

Individual Speech-Language therapy sessions (50-minute sessions)……...……....$140.00
-Fee includes 45 minutes of one-on-one therapy with your child's trained speech-language pathologist and a 5 minute discussion with the parent in the waiting room at the end of the session.

Individual Reading therapy sessions (50-minute sessions).....$100.00
-Fee includes 45 minutes of one-on-one reading intervention with your child's trained literacy specialist and a 5 minute discussion with the parent in the waiting room at the end of the session.

Group speech-language therapy sessions (50-minute sessions)……...…… $100.00*

School or home visits (45-minute sessions)……...…… $135.00

School observations (45-minutes)……...……...……... $135.00

Phone or office consultative services (50-minutes)……...…… $135.00

School or home services (45-minutes).....……..$135.00

* If a dyad or group session becomes an individual session due to another child's cancellation, you will be billed for an individual session.

PLEASE NOTE: Payment is due at the time of services or upon receipt of invoice. If payment is not received within two weeks of receipt of invoice, your credit card will be charged for the total amount due.

I, _____, acknowledge and accept full and complete responsibility for prompt payment for all services rendered to _____ by Chatting Children Speech and Language Center. I acknowledge that I have received written explanation of the fee schedule and the cancellation policy and that I agree to both.

I understand that health insurance policies and reimbursement are between myself and the health insurance company, that all services rendered to my child are charged directly to me, and that I am personally responsible for payment to Julie K. Cotter.

_____

Signature Date

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Policies and Procedures

Chatting Children Speech and Language Center is pleased to have you as a valued family in our practice. We offer a wide range of services and look forward to helping your child improve his/her communication skills. Please read, initial, and sign the following policies and procedures agreement.

Treatment Sessions

Therapy sessions are 45 minutes of treatment and a 5-minute discussion at the end with the parents (total of 50 minutes). You will receive a written treatment note at the end of the session. This treatment note is designed to provide you feedback on that specific session, as well as provide you with homework activities. We believe carryover activities in the home environment are essential to success! Please feel free to ask brief questions at the end of the treatment session, reserving more lengthy discussions for consultation appointments. We need the 10 minutes between clients to disinfect materials and prepare for the next session.

We kindly ask that parents do not sit in the therapy sessions. You are welcome to wait in the waiting room or do a drop-off. If you will be leaving the office during your child's session, please advise your therapist and be sure your cell phone number is on file. Returning to the office 5 minutes before the end of the session is imperative so that the session can be reviewed with you before your therapist's next scheduled appointment. Should tardiness on pick-up become problematic, we reserve the right to charge you our hourly rate for the additional time in office. Therapy sessions are back to back so late pick-ups affect the following client's session.

_____ *(initial here)*

Billing and Insurance

Payment by check or cash is expected at the time of service or upon receipt of invoice. Please make checks payable to **Chatting Children**. If a check is returned for insufficient funds, the additional fee will be charged to your account. Unfortunately, Chatting Children Speech and Language Center does not accept health insurance. It is your responsibility to retain all treatment notes, evaluations, progress reports, invoices and treatment plans to provide to your insurance company. Should you require additional information, you will be charged the hourly rate for the time it requires to collect the material.

_____ *(initial here)*

Cancellations

If you must cancel a session, **please do so in writing (email) 24 hours prior to your appointment to avoid being charged for the session**. Exceptions will be made in cases of emergencies and illness at the discretion of the therapist. Please be mindful that careful individual planning and time goes into preparing for your child's speech-language therapy. We want to maximize your child's potential and progress with consistent therapy sessions. Also be advised that there is an extensive waiting list for current therapy slots. Therefore it is important for you to attend all therapy sessions as scheduled and to arrange for make-up sessions when possible. Should frequent cancellations become problematic, we reserve the right to bill for a minimum of 3 sessions per month in order to hold your time slot. Should you arrive late to your child's therapy session, the session will not go over the allotted time slot, nor can make up time be scheduled. It is your responsibility to arrive on time and pick up your child on time.

_____ *(initial here)*

Inclement Weather and Holidays Policy

Chatting Children **does not follow any local school districts' inclement weather policy or holiday schedule**. Your therapist will contact you if therapy is cancelled due to inclement weather or upcoming holidays. If driving conditions are poor and will prevent you from making your child's appointment, please be sure to contact your therapist as early as possible.

_____ *(initial here)*

School Visits

School visits are 45-minutes in length. It is the parent's responsibility (not the school's) to inform your therapist if your child will not be in school for the following reasons: sick, doctor's appointment, school closings, half days or field trips. You will be billed for sessions not cancelled within 24 hours prior to the scheduled session.

_____ *(initial here)*

Waiting Room Discussions

Your child's therapy session will be discussed with you in the office/waiting area at the end of each session. Please advise your therapist if you do not want to have these brief discussions at that time.

_____ *(initial here)*

Consultative Services

When necessary, we are happy to schedule appointments for phone, office, or school consultations. Please schedule these with your therapist and note that should the consultation require more than 15 minutes, you will be billed our hourly rate for the service.

_____*(initial here)*

Safety Measures

Surveillance cameras are in the office to ensure the safety of our staff, clients and families. Videos will not be publicly released and can only be viewed by the director of this practice, Julie Cotter. Should a situation arise, where video footage of you or your child needs to be released for legal purposes, you will receive notification prior to.

_____ *(initial here)*

I, _____, parent/guardian of _____ acknowledge that I have read and understand the Policies and Procedures regarding speech-language therapy at Chatting Children Speech and Language Center and I accept the terms of agreement.

_____

Signature

_____

Date

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Credit Card Authorization Form

Should payment not be received by the 14th of the month, Chatting Children Speech and Language Center will charge the credit card listed below.

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 _____

Signature _____