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Milestones
Educational Therapy Institute

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:** ___ **Grade:** ___ **School:** _____
Month Day Year

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:** _____ 05/2013

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CHILD HISTORY-INTAKE FORM

General Information:

Child's Name: _____ Date of Birth: _____
Address: _____ Phone #: (____) _____
City: _____ Zip Code: _____
Does child live with both parents? _____
Mother's Name: _____ Age: _____
Mother's Occupation: _____ Work Phone: (____) _____
Father's Name: _____ Age: _____
Father's 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 learning 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 _____
- Tonsillitis _____
- Chicken Pox _____
- Croup _____
- Ear Infections _____
- Headaches _____
- Mastoiditis _____
- Mumps _____
- Sinusitis _____
- 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? _____
_____
_____

Describe any major accidents and/or hospitalizations_____
_____
_____
Is the child taking any medication? If yes, identify.
_____
_____

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

Educational Information:

School: _____ Grade: _____
How is the child doing academically (pre-academically)? _____
_____
_____
Does the child receive special services? If yes, please describe. _____
_____
_____
Has your child ever repeated a grade? _____ If so, explain: _____
_____
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: _____

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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.

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

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Insurance Reimbursement Policy

Dear New Patients,

Milestones Educational Therapy Institute provides clients with services that are considered educational and NOT medical. In the past we have found that because of this, insurance companies do not reimburse our clients for services received at our office. We will provide you with a bill of service, if you wish to submit bills for reimbursement. **We do not contact, follow up with, or submit paper work to your insurance company.**

Thank you,

Judith Benn, M.A.
Founder & Director
Educational Therapist
Certified Dyslexia Remediation Specialist

I understand that Milestones Educational Therapy Institute does not contact, follow up with, or submit paper work to insurance companies for reimbursement:

_____ _____

Signature Date

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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

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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) 979-7575.

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: _____

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Observation Form

Dear New Patient,

From time to time, assistants/students in various clinical/educational training programs ask for the opportunity to do clinical observation in our clinic. We welcome them here, as it enhances their knowledge of learning while in no way disrupting our sessions.

A session will not be observed if either the parent or the student feels uncomfortable about it. Please sign and return this from indicating your preference about observation during your child's session.

Thank you,

Judith Benn

Judith Benn, M.A.
Founder & Director
Educational Therapist
Certified Dyslexia Remediation Specialist

Please choose one of the following:

_____ I give my permission for _____ to be observed on occasion by
Patient's Name
person's in training programs.

_____ I prefer that _____ session not be observed
Patient's Name
by anyone other than Milestones Educational Therapy Institute staff.

_____ _____

Signature Date

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