JMJ Speech & Language Solutions

AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

Phone: 678-278-9244
Fax 678-412-1679
Email: jmjspeechsolutions@outlook.com

Date: _______________

CLIENT HISTORY FORM

Identification

Name_______________________________________ Birthdate_____________________

Address:_____________________________________ Phone_______________________

City__________________________ Zip code___________ Alt Phone_________________

Referred by______________________________ Email Address __________________________

What are your concerns regarding your child's speech and/or language?_____________

____

____

When did you first notice the issue(s)?____

To what do you attribute this problem? ____

Mother's Name ___________________________Home phone _____________________
Address____
Employer_____________________________ Cell or work phone_____________________

Father's Name ___________________________Home phone _____________________
Address____

Employer______________________________ Cell or work phone_____________________

Pediatrician's name, address, and telephone number:_________________________________
____

Pregnancy, Birth History and Early Development

Is this your biological child?____________________ Problems during pregnancy or labor:____________

____

Birth weight___________________________ Condition at birth_________________________________
Problems at or after birth____
Speech/language concerns: when 1st noticed____
Can people understand your child's speech?____

Medical History
Diseases, illnesses, operations

____

____

Present Health Concerns:____

____

Under treatment now? ____
Does your child have seizures_________ Medication?____
Has your child had ear infections: __________How often?________ How treated? __________________
Has he/she had hearing problems? ____

Social/Behavior
What does your child like to do?____

____

Does he/she play well with other children? ____
Do you have concerns about his or her behavior?____
How do you manage his/her behavior? ____

Family History
Siblings & ages____
Are there any family members with similar problems?_____________________________________

School
Does your child attend school or daycare?________ Where?__________________________________
How is he/she doing?____
What concerns do you have with his/her performance?

____

____

____

Evaluations

Has your child had a hearing test? Where? When? What were the results?

Vision test? ____

Previous speech/language evaluation?____
Neurological testing? ____
Psychological testing?
____
Other pertinent tests?____

____________________________________ ______________________________
Parent Date

JMJ Speech & Language Solutions

CONSENT FORM

I agree to have my child, ______________________,
receive a speech language therapy evaluation and/or
treatment.

CONFIDENTIAL RELEASE OF INFORMATION
I hereby authorize JMJ Speech & Language Solutions LLC to
obtain and/or release pertinent information concerning
_______________________ to *Jennifer M. Jones M.Ed.
CCC-SLP.*
It is my understanding that this information will not be shared
with any other
entity without my prior knowledge. I further acknowledge that
the use of this
information is to ensure the best quality of care possible for
my child.

Attendance Policy

I understand that three missed appointments without calling in
advance to cancel may result in being dismissed from JMJ
Speech & Language Solutions

_________________________ ______________
Parent/Guardian Date

Patient Financial Policy

We would like to thank you for choosing JMJ Speech & Language Solutions as your health care provider. This is an agreement between JMJ Speech & Language Solutions and you, the patient or parent of the patient. By signing this agreement, you are agreeing to pay for all services provided to you and on your behalf by JMJ Speech & Language Solutions. Please read the following carefully, and ask if you have any questions.

Please initial each section below.

______ **Payment options if you have insurance:** Insurance is a contract between you and your medical carrier and we are not a party to this contract. We will file insurance claims as a courtesy to our patients. We cannot negotiate issues related to deductibles, co-payments, covered charges, or eligibility. Co-pays are due at time of service. If we have not received payment from your insurance carrier within 60 days, you will be responsible for services rendered. In the event that we receive payment from your insurance carrier after you have paid, we will return the insurance payment directly to you. We will estimate what your insurance carrier will pay, however your insurance company makes the final determination of your eligibility and benefits. If your carrier is not contracted with us, you agree to pay any portion of the charges not covered including those above the usual and customary allowance.

______ **Payment options if you have no insurance:** Payment is due at time of service. You may pay by cash, check, or credit card. We offer a 10% discount for full payment at time of service. Patient financing is available through partner companies.

______ **Referrals and Pre-authorizations:** Your insurance carrier may require a referral from your physician and/or a pre-authorization for us to provide services. It is your responsibility to obtain a referral if required by your insurance company. Please note that failure to obtain a referral and/or pre- authorization may result in a decreased or no payment from your insurance company, and the balance will be your responsibility.

______ **Returned Checks:** There is a fee of $20.00 on all returned checks not honored by the bank.

______ **Past Due Accounts:** Accounts 60 days past due will be assessed a 2% finance charge monthly. If your account becomes past due, we will take steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs incurred, including reasonable lawyer fees and court costs as necessary.

______ **Monthly Statement:** If you have a balance on your account, we will send you a monthly statement. If additional statements are desired, please contact our

billing department.

______ **Cancellation Policy:** Consistency in attending services is important for successful progress. Scheduled appointments are held for you and are not available to others. If you are unable to keep an appointment, please call at least **24 hours** in advance. If appointments are not cancelled 24 hours in advance you will be subject to a $15 fee. No call no shows are $25.

Thank you for the opportunity to provide your health care services. Your assistance and cooperation is appreciated. By signing below, you acknowledge that you have read and understand the financial policies described above, and have had the opportunity to ask questions.

Parent/guardian's signature: ____________________

Print Name: _________________

Date: ______________________

Patient's Name: _________________

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT FORM

By signing this form, I acknowledge that I have received a copy of JMJ Speech & Language Solutions Notice of Privacy Practices.

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CHILD"S NAME

____

PARENT/ GUARDIAN NAME

______________________________________ _______________

PARENT/GUARDIAN SIGNATURE DATE