MILESTONES

Welcome!

Thank you for choosing Milestones Speech and LanguageTherapy. We appreciate the opportunity to assist you with this important process.

The attached new client packet includes important information about this practice including insurance, financial, and privacy policies. Please take time to fill out as much information as possible regarding your child's developmental history as this information can be vital to the direction of the therapy plan. It is important that your therapist has as much information as possible prior to your first visit so that she may provide the best possible service for your child. If your child has any recent evaluations completed by other health professionals (psychologist, IEP, etc.), please bring copies of these with you or you may fax them to Milestones Speech and Language Therapy in advance.

Completed packets may be faxed to (760) 406-4229 or emailed to info@milestonesslp.orgPlease feel free to call our office at (760) 778-6111 with any questions or concerns that you may have. We look forward to meeting you soon!

Sincerely,

Jyll A. Chandler

Jyll Chandler, M.A. CCC-SLP/QOT
Owner/CEO

SG

Appendix B: Sample Trans-inclusive Speech Intake Form

All information on this form is confidential and will be kept in a private and secure location.

IDENTIFYING INFORMATION

Legal name: _____ Date of birth: _____

Preferred name (*if different than legal name*): _____ Today's date: _____

Are you comfortable being contacted by: ☐ Phone (home) ☐ Phone (work) ☐ Email

Home phone: _____ Is it OK to leave a message at this number? ☐ Yes ☐ No

Work phone: _____ Is it OK to leave a message at this number? ☐ Yes ☐ No

Email: _____

Emergency contact person: _____ Their phone: _____

Please inform staff if your contact information changes.

REASON FOR SEEKING SPEECH SERVICES

Describe concerns relating to speech in order of importance.

	Concern	How long has this been a problem?
1.		
2.		
3.		

Have you tried any treatments for this in the past (on your own or with another professional)? ☐ No ☐ Yes

If yes, please describe when, what you tried, and the results: _____

_____

_____

Have you ever had a hearing test? ☐ No ☐ Yes Date: _____ Result: _____

Does your speech change depending on how much you use your voice? How?: _____

_____

Does your voice change when you are under stress? How? _____

_____

MEDICAL HISTORY

Current medication (name + dose):
include herbs/supplements

Allergies:

Surgeries, serious illnesses, injuries, and hospitalizations: Date:

1.

2.

3.

Please check if you have ever had:

- ☐ Allergies
- ☐ Asthma
- ☐ Chronic congested nose
- ☐ Chronic cough
- ☐ Chronic headaches
- ☐ Chronic heartburn/acid reflux
- ☐ Chronic runny nose
- ☐ Chronic sore throat
- ☐ Difficulty breathing
- ☐ Difficulty swallowing
- ☐ Ear infections
- ☐ Frequent need to clear throat
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Loss of voice
- ☐ Pain in ears
- ☐ Pain in jaw
- ☐ Ringing in the ears
- ☐ Sensation of lump in throat
- ☐ Sinus problems
- ☐ Sleep apnea

Have any individuals in your family had serious illnesses or speech/hearing problems? Describe:

OTHER FACTORS THAT MAY AFFECT VOICE

Daily intake of water and other non-caffeinated, non-alcoholic drinks (e.g., milk, juice):

		Approx. start	Approx. end		Current daily consumption
Caffeine *(coffee, tea, soft drinks, chocolate)*	☐ Past			☐ Current	
Alcohol	☐ Past			☐ Current	
Smoking					
• Tobacco	☐ Past			☐ Current	
• Marijuana	☐ Past			☐ Current	
• Crack/Cocaine	☐ Past			☐ Current	
• Amphetamines	☐ Past			☐ Current	
• Other	☐ Past			☐ Current	

All information on this form, including answers in this section, is confidential. We do not discriminate on the basis of past or present drug use.

Do you use your voice in your work? Describe: _____

_____

Do you use your voice for recreation (singing, acting, etc.)? Describe: _____

_____

OTHER HEALTH PROFESSIONALS INVOLVED IN CARE

To assist in coordination of care, it is helpful to know about other health professionals you are seeing. ***Other care providers will not be contacted without your permission***, unless there is a medical emergency.

Name of primary care provider (GP, nurse, etc.): _____

Phone: _____

Other care providers (specialists, counsellors, etc.)

	Name	Phone
1.		
2.		
3.		

Other: _____

OTHER RELEVANT INFORMATION

If there is additional information you would like us to know, please write in the space below:

If you have any questions or concerns, please let us know.

adapted from intake forms used by several programs reviewed for the Trans Care Project

Appendix C: Transgender Self-evaluation Questionnaire

How do you rate your voice? (overall)

Currently my voice is:

- Very female
- Somewhat female
- Gender neutral
- Somewhat male
- Very male

My ideal voice would sound:

- Very female
- Somewhat female
- Gender neutral
- Somewhat male
- Very male

RATING SCALE

1 = never
2 = almost never
3 = sometimes
4 = almost always
5 = always

How often do you experience the following?

			1	2	3	4	5	
F	1	People have difficulty hearing me in a noisy room.	never					always
P	2	I have trouble finding a vocal range that feels authentic to me.	never					always
E	3	My voice makes me feel less feminine(MTF)/masculine(FTM).	never					always
F	4	I feel the pitch range of my voice is restricted.	never					always
P	5	The sound of my voice varies throughout the day.	never					always
F	6	I feel my voice gets in the way of me living as a woman(MTF)/ man(FTM).	never					always
F	7	I use the phone less often than I would like.	never					always
E	8	I'm tense when talking with others because of my voice.	never					always
E	9	I tend to avoid groups of people because of my voice.	never					always
E	10	People seem irritated with my voice.	never					always
P	11	People ask, "What's wrong with your voice?"	never					always
F	12	I speak with friends, neighbours and relatives less often because of my voice.	never					always
F	13	I avoid speaking in public because of my voice.	never					always
P	14	I feel my voice sounds artificial to others.	never					always
P	15	I have to strain to make my voice sound like I want it to.	never					always
E	16	I feel frustrated with trying to change my voice.	never					always
F	17	My voice difficulties restrict my personal and social life.	never					always
P	18	The pitch of my voice is unreliable.	never					always
P	19	When I laugh, cough or sneeze, I sound like a man(MTF)/ woman(FTM).	never					always
F	20	I feel my voice doesn't match my physical appearance.	never					always
P	21	I use a great deal of effort to speak.	never					always
P	22	My voice is worse in the evening.	never					always
F	23	My voice causes me to lose income.	never					always
E	24	I don't feel my voice reflects the "true me".	never					always
E	25	I am less outgoing because of my voice.	never					always
E	26	I feel self-conscious about how strangers perceive my voice.	never					always
P	27	My voice "gives out" in the middle of speaking.	never					always
E	28	I find it upsetting when I'm perceived as a man(MTF)/ woman(FTM) on the phone.	never					always
E	29	I am envious of other women(MTF)/men(FTM) who have more feminine(MTF)/masculine(FTM) voices than mine.	never					always
E	30	My voice embarrasses me.	never					always

MEDICAL RECORDS (HIPAA) RELEASE FORM

A medical records release form is a document that allows us, upon your request, to share treatment information with an outside party, such as an employer, an insurance company, a family member, or doctor or healthcare provider.

Medical release forms protect your privacy and your right to release personal information according to your consent.

Signing this release form is optional and allows us to communicate with other care providers, insurance companies, or family members about the patient's treatment.

Please complete all sections of this medical records (HIPAA) release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

I authorize the release of the following protected health information:

☐ complete records ☐ history & physical ☐ progress notes ☐ treatment record ☐ care plan

other:

I authorize the release of my protected health information to the following individual or entity and/or those directly associated in my medical care:

Name	Phone
Address	**City, State & Zip Code**

The purpose or reason for this release of information is as follows:
(If you do not wish to list the reasons for sharing, select "at my request.")

At my request.

Other:

This authorization to share my health information is valid for the following time period:

All past, present, and future periods.

Until six (6) years from the date of signature.

other:

MEDICAL RECORDS (HIPAA) RELEASE FORM SIGNATURE

By signing this form, I authorize Milestones Speech and Language Therapy to release confidential health information about me or the person in my care by releasing a copy of my medical records or a summary or narrative of my protected health information to the physician, person, facility, and/or entity listed above.

Name of Patient:

Name of Parent or Legal Guardian, if applicable:

Signature:

Date: ___/___/___

If this form has been completed by a person with legal authority to represent the patient, like a medical agent, a parent, or a legal guardian, please complete the following information:

Name of Person Completing this Form:

Signature of Person Completing this Form:

Date: ___/___/___

Describe how the above person has the legal authority to sign this form:

MILESTONES

PARTY RESPONSIBLE FOR PAYMENT

Name:_____ DOB: _____ SSN: _____

Address:_____ Phone:_____

Employer Name: _____Contact Phone: _____

Company Address_____

INSURANCE BILLING INFORMATION:

Card Provided: Y / N

Primary Insured**:** _____ DOB: _____

Primary Insurance : _____ Phone Number:_____

Billing/Claim Address:_____ City:_____

State: _____ ID#:_____ Group #: _____

Secondary Insurance: _____Policyholder Name: _____

DOB: _____ Phone Number: _____

Billing/Claim Address: _____City:_____ State:_____

Policy Group or #: _____ Group #: _____

As a **courtesy**, we will verify your insurance benefits. However, due to continuous inconsistent information provided by the insurance companies, verification is not a guarantee of payment. Payment is ultimately the responsibility of the patient/guarantor. If your insurance does not pay for services, it is YOUR responsibility.

Please bring your driver's license and insurance cards to the first appointment.

Assignment of Benefits (insurance patients only): I _____, authorize the release of any payment and medical information necessary to process my or my family member's insurance claim and related claims. I hereby authorize payment directly to Milestones Speech and Language Therapy of the insurance benefits otherwise payable to me for all professional services.

Signature of Policyholder: _____ Date:_____

MILESTONES

POLICIES AND PROCEDURES

ATTENDANCE POLICY

Clients may NOT be “dropped” off. An adult must be present in the clinic or parking lot while the child is in their appointment. If you must cancel an appointment, please call at least 24 hours in advance. Except under emergency circumstances and acute illness, all appointments canceled with less than 24 hours notice will be subject to a $25 service fee for regular therapy sessions. There will be **ONE** “failure to cancel” courtesy provided. If you arrive 10 minutes late for your scheduled visit, you will be charged a $25 no show fee and will not be seen for your appointment. Please note that most insurance companies will not reimburse for missed appointment fees and you will remain responsible for these charges.

COVID COMPLIANCE AGREEMENT

I agree to abide by the following precautions that Milestones has implemented against the spread of COVID-19 in compliance with city, state, and federal guidelines: All adults must wear masks or face coverings to enter the clinic, parents will wait in vehicle whenever possible, will not congregate in the waiting room or in the hallways, and keep a six-foot distance between people. I agree to contact Milestones if I or my child test positive for COVID-19 or are experiencing fever, chills, cough, sore throat, shortness of breath, headaches, nausea, vomiting, diarrhea, or loss of taste or smell. I will not return to the office without permission from a physician or after isolating for 10-14 days as suggested by the CDC.

CONFIDENTIALLITY

Your privacy is very important to us. We strongly recommend that you review the Notice of Privacy Policy for important details regarding policies for maintaining confidentiality. In particular, you should be aware that we will only contact you via means that you have specifically authorized in your new client paperwork. If you would like us to exchange information with persons other than yourself, an Authorization for Release of Information form must be completed.

FEES

It is the parent/client’s responsibility to verify/clarify charges prior to attending evaluations or treatments. Fees apply to various types of services including direct client contact (clinic based or offsite), phone consultations, travel, and consultation with other professionals.

PAYMENT

The person who completes the Party Responsible for Payment section is responsible for payment of all services rendered. Payment is due at the time services are rendered unless you have made other arrangements in advance. **Accounts more than 30 days overdue will be subject to a $20.00 late fee and 5% interest charge. Accounts more than 90 days overdue will be sent to collections**. For clients seeking third-party reimbursement, please be aware that **you are ultimately responsible for the payment of services rendered. If your insurance carrier denies payment (including recoupment) or does not remit payment within 45 days, the client will be responsible for payment of all services rendered.**

MILESTONES

HEALTH INSURANCE

We participate with some insurance companies, but not all. If Milestones Speech and Language Therapy is not contracted with your insurance, we will be happy to provide you with a superbill to assist you in seeking reimbursement for out-of-network provider services. Please also be advised that many health insurance plans have limited coverage for speech language pathology services. We recommend that you contact your insurance company to discuss the limits of your coverage.

TERMINATION OF SERVICES

In the event that you do not keep your financial obligations to Milestones Speech and Language Therapy and remain delinquent on your account for more than 2 sessions, services will be suspended until payment is received. Services may also be terminated if it is determined that continued participation will be a detriment to the child or their family. Due to the importance of continuity of care, regular attendance to appointments is necessary. Two consecutive missed appointments without office notification will result in removal from the schedule. Families are responsible for reconciling with the front desk in order to resume sessions.

The Speech Language Pathologist reserves the right and professional judgement to discontinue services. Optimal outcomes are the goal, however not guaranteed.

HEALTH POLICY

Help and cooperation is required to maintain a healthy environment. A child must be temperature-free for 24 hours before returning to therapy. If your child has experienced vomiting and/or diarrhea, he/she should not return to therapy until 24 hours have passed since the last episode of the same. Please do not bring sick or febrile family members to the clinic.

Children will not be seen if any of the following is present: Too ill or uncomfortable to function in the therapy setting, continual runny nose; thick or discolored nasal discharge; excessive sneezing or coughing and mucus-producing cough; an elevated temperature.

CONSENT/PAYMENT FORM

This form must be completed before services can be initiated. If the client is under the age of 18 years, the form must be signed by all legal guardians.

Consent for Treatment I hereby attest that I have voluntarily applied for and entered into treatment, or give my consent for the minor or person under my legal guardianship, at Milestones Speech and Language Therapy. I understand that I may terminate these services at any time.

RECEIPT OF POLICIES AND PROCEDURES

I hereby attest that I have received a copy of Milestones Speech and Language Therapy's Policies and Procedures, including payment policies, and have read, understand and consent to be bound by its content.

MILESTONES

CONSENT TO TELETHERAPY

I give consent for myself or my child to participate in speech therapy services via HIPAA compliant video chat.

RECEIPT OF PRIVACY POLICY AND CONSENT FOR DISCLOSURE OF HEALTH INFORMATION

I have been provided a copy of Milestones' Notice of Privacy Policies detailing how my medical record may be used and disclosed under Federal and State law. I understand that as a part of Milestones Speech and Language Therapy's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity (i.e., insurance, emergency, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax and e-mail only to appropriate parties. I fully understand and accept the terms of this Consent and acknowledge the receipt of the Privacy Notice. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I understand that by refusing to sign this consent or revoking this consent, Milestones may refuse to treat me. I further understand that Milestones reserves the right to change its privacy policies and will provide me with a copy of any revised notice.

TEACHING FACILITY

I understand that Milestones is a teaching facility that utilizes students in therapy sessions in order to gain clinical experience. I give permission for students to conduct therapy session under the supervision of the SLPs on site

PHOTO CONSENT

Milestones would like to incorporate our clientele and their families in the marketing

Name of Patient (Printed): _____ Date: _____

By signing below, you are attesting to the accuracy of the above statements including all consents and authorizations implied therein. A copy of this agreement is available upon request.

Legal Guardian Signature: _____ Date: _____

CONSENT TO AUDIO OR VIDEO RECORDING

I consent to allowing this speech therapy session to be recorded via audio or video. I understand the purpose of this recording is to provide assessment points and tools of measurement. I have been advised it will not be released for use in any public material or presentation.

Legal Guardian Signature: _____ Date _____