Patient Update Packet

*Central Delaware Speech-Language Pathology is committed to providing the best care for your child. Please fill out all sections as completely and accurately as possible. If you have any questions, please feel free to contact us.*

Today’s date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the child live with both parents? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, with whom does the child live? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information:**

*Primary:*Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group#\_\_\_\_\_\_\_\_ Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient:\_\_\_\_\_\_\_\_\_\_

*Secondary (If applies):*Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group#\_\_\_\_\_\_\_\_ Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient:\_\_\_\_\_\_\_\_\_\_

**Allergy Information:**

Please list below any allergies (latex, food, medication, or other sensitivities) that your child has.   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**P**

**L** LP P L

**S**

**D** D

**C CCCCC**

Central Delaware Speech Language Pathology, Inc.  
*Specializing in the Diagnosis and Treatment of Speech-Language Disorders*

*ASHA Certified, Licensed in Delaware*

***Our Policies***

*This document is a recap of the Outpatient Service Agreement signed by all client’s parents or guardians. Please read and initial each section to confirm receipt and understanding of each policy. A copy of this document will be provided for you.*

***Commitment*:** We provide telephone or email reminders of appointments based on your preference. Appointment cancellations and/or rescheduling must be made at least 24 hours prior to appointment. **While we are aware that emergencies happen, more than 1 cancellation with less than 24 hours notice within a calendar year may result in billed time for missed appointments and/or changes to your future appointment schedule.** In the infrequent event that a therapist must cancel an appointment, we will offer choices for rescheduling.

I prefer email appointment reminders Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I prefer phone call reminders Preferred Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Initials\_\_\_\_\_\_\_\_\_\_\_\_\_

***Scheduling*:** Our scheduling policy is as follows: We do our best to schedule appointments based on each family’s preferences and needs. In the event that multiple families absolutely need the same appointment time, we will draw randomly for the spot. In the event a family needs a schedule change once we have established the schedule, we are always willing to *ask* another family to move, however; we may not force them to move to accommodate someone else.

Parent/Guardian Initials\_\_\_\_\_\_\_\_\_\_\_\_\_

***Billing*: Payments are due at the time service is rendered**. This includes services not covered by insurance and insurance co-pays. Once your outstanding personal balance exceeds $100, we will no longer be able to schedule appointments until the balance has been paid. CDSLP is not responsible for any insurance or income changes that may effect your child’s therapy fees. Ultimately, it is your responsibility to understand your benefits, what services are covered, and to notify the front office of any insurance changes.

Parent/Guardian Initials\_\_\_\_\_\_\_\_\_\_\_\_\_

***Parent/Guardian Presence*:** A parent or guardian **must** remain in the building throughout the child’s therapy session in case of emergency or assistance is needed. **No exceptions.** Please do not ask the staff to waive this policy as they are not permitted to do so. Staff are not responsible to ensure that any child, whether patient or sibling, is supervised. Supervision is solely the responsibility of the attending parent or guardian.

Parent/Guardian Initials\_\_\_\_\_\_\_\_\_\_\_\_

***Divorced/Separated Families:*** Shared parental decision-making responsibility, known as “joint custody”, means that each parent has equal access to the child or children’s medical records. When asked, we will discuss appointment, scheduling, and treatment details with the requesting parent. We will **not** routinely notify the other parent when a child is being seen in our office, call the other parent for consent to treat or notify if the other parent has moved/made changes to their child’s appointment. Appointment reminders will be made as normal to the phone number/email address on file. Central Delaware Speech-Language Pathology will assume that both parents share joint custody, communicate, and make decisions based on their child’s care together **unless** otherwise declared in writing.

Parent/Guardian Initials\_\_\_\_\_\_\_\_\_\_\_\_\_

*By signing below, you agree to all policies listed above and verify that all information listed above is complete and correct to the best of your knowledge.*   
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Child’s Name Date Parent/Guardian Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date