Susan Freiman Ross, MA, CCC–SLP Licensed Speech-Language Pathologist
Santa Monica Speech Pathology
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NEW CLIENT FORM

Thank you for taking the time to complete this form prior to your visit.

Today's Date: Child's Birthdate:

Child's Age: Child's Sex:

Child's Name: Child's Nickname:

Parent's Name: Occupation:

Home Address:

Home Phone: Cell:

Email:

Parent's Name: Occupation:

Home Address (if different):

Home Phone: (if different): Cell:

Email:

Caregiver's Name: Cell:

Siblings (names, ages):

Other languages spoken in the home:

History of speech/language/learning problems in the family (who, what type):

Referred by:

YOUR CHILD

Is your child: Biological: Adopted:

Notable circumstances during pregnancy, delivery, and/or following birth:

Hospitalizations, accidents, surgeries or significant illnesses, including dates:

Ear infections? (If yes, how many, approximate dates):

Results and date of last hearing test:

Allergies or asthma (If yes, explain):

Medications your child is currently taking:

Other health professionals your child is currently seeing:

Your concern(s) regarding your child's speech and/or language:

When you first noticed the issue(s):

Your child's awareness of the issue(s):

How it affects your child:

Has your child met other developmental milestones in a timely manner? (If not, please explain):

Other areas of concern you have regarding your child:

School your child attends and grade (If appropriate):

Describe your child's strengths:

Describe your child's challenges:

Anything else you'd like to mention that would be helpful in evaluating/working with your child:

Authorization for Release of Protected Health Information

Child's name:

Address:

City, State, Zip Code:

Birth Date:

I hereby authorize Susan Freiman Ross to discuss and/or release pertinent health information regarding my child to the following facilities. This includes medical records, clinic notes and any pertinent information that will help in treating my child.

Doctor/Facility:
Address:
City, State, Zip Code:
Phone:

Doctor/Facility:
Address:
City, State, Zip Code:
Phone:

Parent/Legal Guardian:

Address:

City, State, Zip Code:

Phone:

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Signature of Parent/Legal Guardian Date Signed

Policies and Procedures

Therapy sessions are **30** minutes. You are welcome to stay and observe if you wish. If you leave, please be in the waiting room 5 to 10 minutes before the end of your child's session.

If you need to cancel or reschedule an appointment, please notify me as soon as possible, at least 24 hours in advance, otherwise you will be held responsible for full payment.

If your child appears to be ill, please cancel her/his appointment.

All insurance reports will be submitted upon receipt of written request from the insurance company

Speech pathology services are provided with the understanding that payment for such services is the responsibility of the parent or guardian. Payment is expected at the time of service. Santa Monica Speech Pathology does not accept direct insurance billing but will assist you in gaining the benefits due you. There is no express or implied representation that your insurance company will in fact recognize speech pathology services as an allowed benefit to you.

I have read and agree to these policies.

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Parent/Legal Guardian   Date Signed

____Date Signed