520 Montana Avenue Santa Monica CA 90403 / 310-739-9337 / lisakleinspeech@yahoo.com / www.lisakleinspeech.com

PATIENT REGISTRATION

Welcome to Lisa Klein Speech. We are delighted that you have chosen us to be your therapy provider. This Patient Registration form must be completed, signed and received by Lisa Klein Speech before any therapy services are provided. The Patient Registration form contains:

1. Patient Information
2. Patient Policies
3. Credit Card Authorization
4. Patient Privacy Notice
5. Patient Acknowledgement

1. PATIENT INFORMATION

PATIENT INFORMATION	
Name of patient:	Nickname:
Date of birth:	Age:
Street address:	State:
City:	Zip:
Home phone:	
FAMILY INFORMATION	
Parent/Guardian 1 name:	Parent/Guardian 2 name:
Parent/Guardian 1 address:	Parent/Guardian 2 address:
Parent/Guardian 1 cell phone:	Parent/Guardian 2 cell phone:
Parent/Guardian 1 home phone:	Parent/Guardian 2 home phone:
Parent/Guardian 1 work phone:	Parent/Guardian 2 work phone:
Parent/Guardian 1 email:	Parent/Guardian 2 email:
Parent/Guardian 1 occupation:	Parent/Guardian 2 occupation:
MEDICAL PROFESSIONALS	
Primary Doctor Name:	Doctor Phone:
Dentist Name:	Dentist Phone:
Orthodontist Name:	Orthodontist Phone:

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CURRENT THERAPY	
Type of therapy: Frequency: Therapist name: Therapist phone:	Type of therapy: Frequency: Therapist name: Therapist phone:
Type of therapy: Frequency: Therapist name: Therapist phone:	Type of therapy: Frequency: Therapist name: Therapist phone:
CURRENT SCHOOL	
School name:	
Grade level:	
Days attended:	
Times attended:	
FAVORITES	
Favorite Toys:	
Favorite Foods:	
Favorite Drinks:	
Favorite People:	
FOOD ALLERGIES	
Please list any food allergies:	
PATIENT GOALS	
Please detail your goals while attending Speech Therapy:	

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2. PATIENT POLICIES

Payment
We invoice monthly on the last day of each month and will forward your invoice via electronic mail. Payment via **cash, check** or **credit card** is due on receipt of the invoice, however if choosing to pay via credit card a 3.5% processing fee will be added to cover our costs. If paying via cash or check, your credit card information will still be requested (see below) and kept on file. If payment is not received by the 10th of the month your credit card will be charged on the 11th day and will include the additional 3.5% processing fee.

Reports
Re-evaluation, yearly progress reports, program plan updates and/or annual reviews with goals and objectives are not included in your current rates. We will charge an additional hourly rate of $190 per assessment and preparation of materials requested.

Lateness
If a client is late they only receive therapy for the time slot they were assigned, as we see clients back to back on many days. For example, if a client arrives at 4:15 pm for a 4:00 pm 30 minute session, the session will still end at 4:30 pm without any adjustment to the fee. Please be on time for your session to assist in maximum progress gains. The office is not a drop off facility, however, if you choose to leave your child, please be back at least 10 minutes prior to the end of session. This will allow us to go over exercises, and begin the next session on time.

Traveling Fee
If the traveling time exceeds 10 minutes for a co-treatment or school observation, an additional fee of $25 per 10 minutes will be added to the session.

Email
You give permission for Lisa Klein Speech to contact you through electronic mail (e-mail) at the e-mail address that you provided on the Patient Registration form regarding general information about your child's progress, scheduling and cancellations.

Cancellations/No Show
All appointments missed without 24 hours or more cancellation notice will be considered a "no show" and billed at the full cost of the scheduled appointment. Cancellations with 24 hours or more notice will not be charged.

Waiting Room and Treatment Etiquette
You are more than welcome to accompany your child into the treatment room. We ask that no more than one adult (and infant) come back to the therapy room. We ask that you do not bring siblings, friends, cousins, etc back to the therapy room with the child as it is very distracting for both the child and the therapist. If you bring other children with you to wait in the waiting room, we ask that an adult stays in the waiting room to supervise them. If you decide to leave the premises during your child's appointment, please know that you are doing so at your own risk. We ask that you return before the child's appointment is over. If you are late, we will ask that you not leave the premises during an appointment.

In-Treatment Media Consent
Upon signing the Patient Acknowledgement at the end of this document, you give permission for you and/or your child to be video recorded during evaluation and treatment. Video recording is optional and at the discretion of the therapist. You understand that this video may be used as an educational tool during evaluation and therapy, and may be shown to other health professionals referenced in this document, for analysis and interpretation. I also understand that I will receive no financial compensation for this video recording.

Confidentiality
Your privacy is very important to us. We strongly recommend that you review the Privacy Notice for important details regarding policies for maintaining confidentiality (see below). In particular, you should be aware that we will only contact you via the means that you have specifically authorized in your new client paperwork. If you would like us to exchange information with persons other than yourself and health professionals referenced in this document, an Authorization For Release Of Information Form must be completed.

Termination
At our discretion, Lisa Klein Speech may terminate a client based on their behavior, and/or their family's behavior that may interfere with the client-therapist relationship and the client's success.

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3. CREDIT CARD AUTHORIZATION

Payment is required by **cash, check** or **credit card** upon receipt of your invoice on the last day of each month, however we do require clients to sign the below Credit Card Authorization in case of overdue accounts. If paying via cash or check and the payment of your invoice is not received by the 10th of the month your credit card will be charged on the 11th day and will include an additional 3.5% processing fee.

Name on Card:
Please circle one: MasterCard Visa American Express Discover
Credit Card Number:
Expiration Date:
Security Code:
Credit Card Billing: Address: City: State: Zipcode:
I authorize this credit card to be charged if I have not paid my invoice by the 10th of the month. I understand that my credit card will be charged on the 11th day and will include an additional 3.5% late fee. Cardholder's Signature: Date:

4. PATIENT PRIVACY NOTICE

Lisa Klein Speech is required by law to keep your health information safe. This information may include:

- notes from your doctor, teacher, or other health care provider
- your medical history
- your test results
- treatment notes
- insurance information

As also required by law, we provide access to a copy of the Lisa Klein Speech Privacy Notice. This notice tells you how your health information may be used and shared and how you may get access to this information. You can request a paper copy of the Privacy Notice from the office of Lisa Klein Speech, or view and download the notice on the Lisa Klein Speech website www.lisakleinspeech.com. By signing the below Patient Acknowledgement you are giving Lisa Klein Speech permission to discuss you or your child's case and share information with the health professionals referenced in this document, either in person, or via email or phone.

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5. PATIENT ACKNOWLEDGEMENT

This form must be completed and signed before services can be initiated. If the client is under the age of 18 years, it must be signed by a legal guardian.

By signing below, you are acknowledging that you have provided true and accurate patient information in the Patient Registration form and Credit Card Authorization, that you have read and agreed to the terms and conditions in the Patient Policies, and that you have been given access to a copy of the Patient Privacy Notice and understand and agree to its content.

Patient Printed Name	Patient Signature (if over 18)
Parent/Guardian Printed Name (if patient under 18)	Parent/Guardian Signature (if patient under 18)
Relationship to Patient (if under 18)	Date