Robyn Merkel-Walsh MA, CCC-SLP
Licensed Speech Pathologist NJL#YS003053
Oral-Motor/Feeding/PROMPT
Myofunctional Therapy
Talk Tools® Instructor

Member of ASHA, NJSHA, AAPPSPA
www.talktools.com
SLS School Certified
robynslp95@aol.com

480 Bergen Blvd. Suite 3
Ridgefield, NJ 07657
Tel 201-945-6200
Fax 201-945-6201

Dear Client-

These forms are for your upcoming evaluation.

Please follow these steps to ensure your time slot is reserved:

1. Print this document completely.
2. Save this sheet as a reminder for the day of the session.
3. Fill out the case history, privacy form and evaluation contract.
4. Mail these forms with the deposit check/money order to the address listed above.

Please use this checklist on the day of your evaluation:

_____ Print the directions on the website for reference the navigation may not always be accurate
_____ Please be sure to bring a check or cash for the balance of your evaluation.
_____ Please bring the foods/drink listed on the evaluation contract.
_____ Please be courteous of the parking and arrival time information on the evaluation contract

MANY THANKS!

Robyn Merkel-Walsh MA, CCC-SLP

Case History Information

Date: _____

Name: _____ DOB: _____

Address: _____ Age: _____

_____ Home Phone: _____

_____ Cell Phone: _____

Referral Source: _____ Email: _____

What is your concern about your child's communication /feeding abilities?

School Placement: _____

Classification: _____

Current Services:

PT _____ OT: _____ ST: _____

Pediatrician's Name and Address:

I. FAMILY HISTORY

Mother's Name _____ Age _____
Occupation _____ Place of Birth_____
Father's Name _____ Age _____
Occupation _____ Place of Birth_____

Who lives in the home?

Name	Age	Relationship

2. What languages are spoken at home?

3. Is there any history of speech or language problems in the family? If yes, please describe.

4. Is there any history of hearing problems in the family? If yes, please describe.

5. Describe any significant family medical, learning or emotional history.

6. Have any other specialists seen the child? If so, what were the other specialists' conclusions or recommendations?

II. BIRTH HISTORY

Length of pregnancy: _____weeks. Did you smoke cigarettes, drink alcoholic beverages, take medication or use drugs during your pregnancy?

Were there any complications during pregnancy? If so, please explain.

Were there any problems during labor and delivery? If so, please explain. Was delivery vaginal or by caesarean section?

What was the child's weight and general condition at birth?

III. MEDICAL HISTORY

Has your child been hospitalized? If so, include age, reason and length of stay.

History of illness, including age.

History of accidents, including age.

How would you describe your child's general health?

Does your child have allergies or frequent colds? If so, describe.

Is your child currently under a doctor's care? Is s/he taking any medication? If so, what kind and why?

Has your child's hearing been tested? If so, when and what are the results?

Does your child have a history of middle ear infections? If so, include when and how often. Has s/he required ear surgery?

Has your child's vision been tested? What were the results?

IV. DEVELOPMENTAL HISTORY

At what age did your child?

roll over_____ stand independently_____
sit independently_____ walk independently_____
crawl _____ toilet train_____
finger feed_____ self-feed with utensils_____
First vocalize_____ Babble_____
Say first words_____ Combine words_____
Talk in complete sentences_____

Oral/Feeding Habits

Has your child had any feeding difficulties? (e.g., drooling, swallowing). Include breast or bottle feeding issues if applicable.

Does s/he avoid any foods?

When did your child wean from a bottle?

Did your child use a sippy cup for more than 3-6 months?

Does your child use a straw to drink liquids?

When did your child stop sucking his/her thumb or digits?

Did your child use a pacifier? If so, for how long?

Does your child grind his teeth/ or tense his jaw?

Does your child exhibit open mouth posture and mouth breath?

Is your child sensitive to textures?

Is your child sensitive to sounds?

Is your child sensitive to smell?

Does your child exhibit any self-stimulatory behaviors such as flapping or saying words over and over? If so describe:

Does your child seem to have any balance or coordination difficulties? If so, please describe.

How well does your child sleep?

How does your child currently communicate his/her wants and needs?

How clear is your child's speech?

How well does your child understand what is being said to him/her?

V. SOCIAL HISTORY

How would you describe your child's personality?

Describe your child's socialization skills with family and familiar people.

How does your child react to unfamiliar people and/or situations?

How does your child interact with other children?

What are your child's favorite activities/hobbies?

Describe your child's activity level.

VII. If there is any other information about your child that would be helpful in evaluating his/her speech/feeding abilities? Please explain or bring additional records to your test session.

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PRIVACY POLICIES AND DISCLOSURE FORMS

NAME OF CLIENT	
ADDRESS	
PHONE #S	
SCHOOL	
PEDIATRICIAN	
INSURANCE	

I _____ parent of _____ give Robyn Merkel Walsh , Speech Pathologist, permission to discuss my child's case with the following individuals via in person , email, or phone:

NAME	**PHONE # / EMAIL**

Signed:

_____

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE DISCLOSED AND HOW YOU MAY HAVE ACCESS TO YOUR "PROTECTED HEALTH INFORMATION" (PHI). PLEASE REVIEW THIS INFORMATION CAREFULLY, AND SIGN THIS FORM BELOW AFTER READING IT.

We care about our patients' rights and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practice. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information.

Who Will Follow This Notice

Any health care professional authorized to enter information into your medical record, all employees, staff, and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes, or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish this task will be shared.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment

We may use medical information about you to provide you with medical treatment or services. Example: In treating for specific motor-speech, or language impairment, we may need medical diagnoses from neurologists or other physicians. This office may use your PHI in providing health care to you. We may use your PHI during office visits or when providing health care in a hospital setting. Under federal law, we may disclose your PHI to you or when we forward your medical information to that physician. We can also disclose your PHI for payment purposes (such as your insurance provider, employer, Medicare or other parties responsible for providing you with health insurance coverage) so that you may be reimbursed for your services. We may also use your PHI for health care operations (quality assurance and medical chart reviews). We may disclose your PHI when required by the secretary of the US Department of Health and Human Services.

For Payment

We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company, or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company or school district for payment. Diagnostic and Procedure Codes are required for payment from insurance companies.

For Health Care Operations

We may use and disclose medical information about you to health care operations (including employees of Good Talking People LLC, speech pathologists, and medical professionals) to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- In response to a legal proceeding
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

Patient Acknowledgement of Notice of Privacy Practices
(As previously stated)

Patient Name: _____

Date of Birth: ____/____/____

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice will provide me a revised Notice of Privacy Practices upon request.

_____ _____

(Signature) (Relationship to patient)

_____/_____/_____

(Today's Date)

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EVALUATION CONTRACT

PLEASE READ ALL THE INFORMATION ON THIS FORM.

Thank you for selecting my office for an evaluation. Since my evaluations are very detailed and specialized it is important that I take extra care in booking your appointment and reviewing your records.

1. Please arrive for your evaluation with ample time for travel, parking and toileting. For privacy I ask patients to enter the facility no sooner than 10 minutes prior to the session. I will start on time and end on time, even if you are late.

2. Parking is available in a lot located behind my office or on the street. Please do not block other cars or take up two spaces. The office entrance is on the side of the building. Please ring the bell labeled "speech". I will buzz you in.

3. Please make sure you come prepared with the following items: (NO NUTS PLEASE)
   - ✓ Crunchy snack (pretzels, chips, crackers) if tolerated
   - ✓ Puree snack (applesauce, yogurt, pudding) if tolerated
   - ✓ liquid/drink (and the bottle, straw or cup your child regularly uses)
   - ✓ highly motivating reinforcers if you feel they are necessary

4. Please be advised that you must send a deposit designated by the therapist ($50 for consults and $150 for full evaluations) in check or money order, within 7 days of booking your appointment in order for the time slot to be held. This fee includes the review your records, and communications prior to the evaluation.

5. Please note that you must cancel your evaluation 72 hours (3 days) in order to receive your deposit back. *(Minus time already taken to review your files, records etc.)* Failure to cancel your appointment or a "no show" will result in loss of your deposit, in which case your check/money order will not be returned. If there is an emergency, contact me at robynslp95@aol.com 24/7.

6. The balance is due at the test session in check or money order only. *CREDIT CARDS ARE NOT ACCEPTED IN MY OFFICE.*

Thanks so much for your cooperation. I look forward to meeting you and helping your child!

Robyn Merkel Walsh MA, CCC-SLP

I _____ understand that mailing a deposit to Robyn Merkel Walsh is to reserve an evaluation. I have read the aforementioned evaluation policy. I also understand that if I do not cancel with 72 hours' notice that I am subject to being charged a cancellation fee / waiving my deposit. I also understand that the therapist cannot account for lateness and my slot will end at the designated time given.

Signed:

_____